

# THE MEDICAL AND SURGICAL REPORTER.

No. 1892.

PHILADELPHIA, JUNE 3, 1893.

VOL. LXVIII—No. 22

## ORIGINAL ARTICLES.

### THE TREATMENT OF GASTRO-INTESTINAL CATARRH IN CHILDREN.\*

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Many authorities on children's diseases still retain the term "functional disturbances of digestion," including vomiting, simple diarrhoeas, etc., and defining these as being without lesion. Others, again, as Louis Starr, regard all catarrhal states as practically involving a lesion, although a very transitory one and generally non-demonstrable post-mortem. In an extended experience in these disorders it has seemed to me wiser to regard them all as dependent upon the lesion of an active catarrhal process whether that be temporary or involves structural changes.

#### ACUTE GASTRIC CATARRH OR PERSISTENT VOMITING.

A very common disorder of infancy arising from irritative conditions of the stomach, or accompanying manifestations of acute disease, such as the exanthemata. The most common cause is unsuitable food whether due to some disturbances of the mother's milk—in which case it is necessary to regard the mother as the avenue of treatment—or, in hand-fed children, to any of the numberless opportunities for causing damage which arise in the preparation of artificial food.

The *symptoms* are chiefly those of discomfort, listlessness, lack of appetite soon followed by vomiting of fermenting sub-

stances, curdled milk or whatever the stomach may contain of food residue along with mucus. There is likely to be some fever, an acceleration of the pulse, tenderness over the epigastrium, and all these symptoms may last for thirty-six or forty-eight hours. In a vigorous child the whole episode often passes with a gush of loose faeces.

If it may be definitely ascertained that there is nothing behind all this the simplest treatment only is necessary to bring about a cure with the utmost promptitude. The essential indication is to neutralize the hyperacidity of the stomach, due to organic acids, and possibly the employment of a mild laxative. The important elements of treatment consist in thoroughly investigating the condition of the food supply—for example, the health of the mother and the quality of her milk and correcting whatever faulty conditions may prevail. Watch must be maintained if a specific trouble threaten. It is well to bear in mind that the specific fevers very rarely arise in a child under six months of age.

#### CHRONIC GASTRIC CATARRH, OR PERSISTENT OR RECURRING VOMITING.

Here there is a distinct hyperæmia of the gastric mucosa which membrane gradually becomes thickened and loosened, changing in color and voiding sticky mucus, or at times even some little mucus. The gastric secretions are lessened,

\*Read Before the Atlantic County Medical Society at Atlantic City, May 3rd, 1893.

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certainly in efficiency, and considerable depression of health obtains. The largest number of cases arise between four and seven months, coinciding with, if not dependent upon, the development of the first teeth.

The causes responsible are whatever influences lower vitality—poor hygiene, early weaning, or, above all, bad hand-feeding. As a matter of fact, the mother who is capable of nursing a child is a very rare animal, not only because of incapacity to secrete a wholesome quality of milk or maintain this for any length of time, but especially in that the modern mother, unless under most exceptional circumstances, is subject to numberless disturbing causes—physical and particularly emotional—and many the result of necessity such as over-fatigue from laborious occupations. Any of these, or more likely all together, soon inhibits the average mother, in the upper classes even more than in the lower, from maintaining a suitable food supply for her offspring. I have several times seen children die in a very few hours from profound disturbance of a mother's emotions.

Next we have to deal with poor milk even though it be good originally. Milk is subject to such an array of deteriorating influences that it is most difficult to place it before the little consumer in anything like a respectable condition. As to how milk should be cared for from the beginning I will speak further on. The bottle-fed infant must, above all things, have the bottles kept absolutely clean. Nor is this so difficult a matter if certain very simple rules are clearly laid down by the physician. My directions to mothers at the Dispensary of the Children's Hospital and at the Polyclinic Hospital, where the service is a large one, are usually printed and handed to them, and are as follows: There should be in use at least three bottles and a half dozen short rubber nipples; a common kitchen bowl filled with a solution of bicarbonate of soda in boiled water. One bottle should be in use; another standing near the fire filled with the soda solution and a third bottle drying in a sunny place. The extra nipple should be floating about in the soda solution. These to be used in constant rotation, cleaned out each time, rinsed with the alkaline wash and treated as described. The long flexible tube has

happily been almost banished from every civilized community.

In children under eight months, no farinaceous foods are suitable, not even the digested starches; only the animal foods are safe for such young infants—either milk in some form, or broths. It should be known to every mother that children are incapable of digesting starch foods until nearly a year old, but, alas, many medical men fail to bear this sufficiently in mind.

The dangers of the subacute catarrhal state of the stomach in infants are very great, not only from death from exhaustion, but from the profound depression of vitality, leaving them fertile ground in which the seeds of disease may flourish.

The treatment depends almost entirely upon the regeneration of the food conditions. A thorough investigation of the quality of the milk when it comes to the house, strict inquiry into the vessels which contain that milk after it has been received, complete isolation of this from any filthy odors or volatile principles which may contaminate this very sensitive fluid and, finally, such treatment of the milk as the condition demands.

Treatment of the milk may oftentimes, with advantage, consist of sterilization. Sterilization has been drummed into the heads of the medical people, and into the minds of the laity likewise, as being the greatest panacea and cure-all for every childish ailment—a preventive of all threatened diseases, even of tuberculosis. These great hopes have been by no manner of means fulfilled. Sterilization, or the bringing of milk up to a heat just short of boiling, thereby destroying contained germs and otherwise producing conditions which make the milk more readily accepted by an irritable stomach, is a very valuable measure, with this inevitable proviso: *Whenever the occasion for its use has passed by, let there be as speedily as possible a return to good cow's milk unchanged.* Sterilized milk will not maintain a child for any considerable period in the same degree of vigor, nor with proper increment of growth, as will normal milk. Indeed, as Professor Albert Leeds has recently pointed out, the varieties and numbers of bacteria in milk are far less than the public have grown to believe. Tuberculosis sometimes does insidiously reach the unsuspecting victim through

this avenue but rarely, very rarely. Other microbic dangers do exist in milk, but not nearly to such an extent as we medical men have been teaching or have been taught. The method of *Pasteurization*, or heating milk up to about 150° Fahrenheit, does nearly all that may be reasonably required, unless the milk supply is distinctly suspicious.

A good method of preparing the day's supply of milk is to take half a dozen stout pint bottles, thoroughly cleanse and fill them with the milk, and stopper them with absorbent cotton thrust into the nozzle. These are to be placed in a pan of water and the water brought to a boil for about ten minutes. This drives objectionable gases from the milk and kills all ordinary forms of bacteria. The cotton prevents the re-entrance, at least for a long time, of germs floating in the air. These bottles put upon the ice, furnish very respectably prepared rations for a child.

This milk diluted somewhat with boiling water for the very young, or not at all for those of nearly a year, guarded perhaps by a little alkali, as lime water, will do for a healthy infant. If the digestion be weak, or, as in the matter under consideration, markedly disturbed, other conditions may be maintained. Among the best of these, to my mind, is peptonization by the cold process as recommended by the Fairchild firm. Two grains of extract of pancreatin and five grains of bicarbonate of soda rubbed up with a tablespoonful of milk, then the proportionate amounts of milk and water added to fill a six ounce nursing bottle, and all this plunged in hot water until the milk be somewhat warmed, then slowly and cautiously administered about every two hours, will usually suffice.

It is a rule abundantly confirmed that fresh cow's milk is much better than any artificial preparation, but it is also a matter of experience that it is frequently impossible to get good, fresh, sound cow's milk and we are inevitably driven to the manufacturing chemists for an alternate.

Among these may be mentioned malted milk, which I have known to prove of very great service. A family of three children under my direction, in a place where good, fresh cow's milk could not be had, were brought up upon malted milk and water and nothing else, from birth

until a year of age, and they are very vigorous well-developed children to-day.

Ordinary condensed milk contains a great excess of cane sugar, which readily undergoes acetic acid fermentation and should be avoided when possible, but even for this a good word must be said, because it is a matter of experience that many times, when driven to the use of this imperfect substance, children not thriving on what should have been a better food, do surprisingly well.

Again, while theories would seem to show it impossible, it is known that babies have been raised in fairly good shape, upon so contemptible a fluid as veal or chicken broth and survived to be a credit to their race.

*Skin Conditions.*—The bath is important, but in very young babies the medium need not always be water. For several years, while attending a considerable number of dispensary obstetric cases I pursued the plan of having all children bathed in clean sweet oil and not water, and the results were eminently satisfactory. Bath-chill was thus averted and the irritations caused by varying qualities of soap, etc., were spared the youngster and I believe that when this line is pursued, better results are had than by the use of soap and water.

My own children were treated thus until three months of age and the nurse admitted that the trouble was less than with water and stoutly averred that the children's skins were much better.

*Clothing.*—The normal clothing, at least the under-clothing, for an infant is wool or possibly silk, summer and winter. No other fabric is safe. The vicious habit of exposing little babies' legs to the sudden changes of our American climate cannot be too sweepingly condemned. Undoubtedly many children survive such maltreatment, but it can with equal certainty be demonstrated that this baring of the knees and arms invites surface chill which results in our American catarrhal stomach. Far worse, since maternal vanity is responsible for many tiny graves.

In this gastric catarrh there is usually a subnormal temperature in the late reaction from the feverishness which often arises, and in this condition of depressed vitality, where the heat-making power is less and where the accompanying leaky skin expedites the loss of body heat, chill

of the internal organs is almost inevitable. Thus, little increments of hyperæmia are caused in the internal organs which may seem trivial but almost certainly do damage to the alimentary tract.

#### GASTRO-INTESTINAL CATARRH.

This condition prevails largely among children who have passed the first dentition, and may be divided into the lesser *Indigestion*—a disturbance which comes and goes—and the greater *Mucous Disease*.

A gastro-intestinal catarrh may arise in a robust child and, with little or no treatment, speedily subside. In children who are less resilient, or more locally susceptible, this becomes a fixed condition called originally by Eustace Smith, of London, by the excellent name *mucous disease*, and must receive special consideration.

To begin with *indigestion*, or gastro-intestinal catarrh. The causes are many: unfavorable surroundings, deficient light and air, too little of out-door exercise and too much of school or in-door coddling, and along with the undoubted susceptibility which exists at the time of the eruption of the permanent teeth, injudicious food and insufficient clothing, all conspire to bring about a very common and troublesome malady of childhood. This disorder prevails less in summer than in winter because there the conditions of life of the average child are simpler and more wholesome. The out-door exercise, so needful for the young, keeps the blood upon the surface of the body and the circulation is more uniform. There are more reasons than can be enumerated here for the necessity of open air exercise in maintaining the ebb and flow of the vital activities.

The chief cause, however, of gastro-intestinal catarrh is coarse, indigestible food. This acts as an irritant upon the mucous surfaces which may already have suffered some depreciation due to these remoter causes depressing vitality enumerated above. An excess of mucus, which in itself is an active ferment, is poured out; hence arise fermentative processes and the resultant organic acids. These, along with masses of coarse food, irritate the intestine and a long train of disturbances result. An attack of vomiting and purging may arise which for the time being clears out both stomach and intes-

tine. Unless the causes are removed and the food more carefully selected, it recurs again and again. The mass of mucus mechanically interferes with the absorption of the digested material, the blood is insufficiently replenished and hence the organic activities are lowered and the gastric and intestinal juices deteriorate. Thus is there direct and indirect reaction.

Extension of the catarrhal processes from the air passages is frequently an avenue of mischief, and I have often seen children and adults as well, in whom an acute attack of vomiting and purging would follow cold in the nose. Sufferers from this trouble become spare, flabby and pale, with a leaky skin, rough and inelastic to touch; a weak pulse, with irritable heart; tongue marked by the teeth, literally "indented;" the tonsils are likely to become hypertrophied; the sluggishness in secretions causes vitiation, and hence arises the mawkish odor of the breath; the cervical glands are enlarged; the belly becomes prominent or depressed alternately, a certain amount of pain occurs along the track of the colon, especially where sharp turns are made, as in the right and left hypochondrium; rumbling of gas in the intestines, and a generally variable and capricious appetite.

#### MUCOUS DISEASE, OR CHRONIC GASTRO-INTESTINAL CATARRH.

A troublesome disturbance of digestion which arises after the first dentition. *Mucous disease*, is to my mind an excellent name for a condition extremely prevalent among American children. Many times not recognized, it is a fertile source of serious mischief.

The lesions are similar to those of *indigestion* but much more severe and extensive. It is usually seen between three or four and twelve years of age—during the establishment and completion of the second dentition. Starr points out that it is especially the resultant of whooping-cough. While there is a considerable number of scoffers, and among them, too, some able men, who love to insist that "teething" produces nothing but teeth, undoubtedly there is a profound disturbance of nervous balance during this period, at least when the eruption of a tooth or teeth, is imminent. The hyperæmia of dentition seems to be reflected throughout the length of the alimentary

canal. Certainly *something* produces increased secretory activity and greater susceptibility to irritants.

The causes enumerated under *indigestion* also obtain here.

The symptoms are those of indigestion magnified and persistent. A steady emaciation prevails; the muscles fall into a condition of pitiable weakness; curious vaso-motor conditions occur; pallor, occasionally varied, especially in the afternoons and under conditions of excitement, by circumscribed flushing of one or both cheeks is noticed; along with this there may be pallor of the lips; this pallor may alternate with cyanosis, until the child looks as if it might faint at any moment, indeed, a very little excitement or fatigue will cause it to do so; the skin is usually sallow, leaky, and flabby to the touch; in places a mild pityriasis occurs and little branny scales fall from the surface; the hair grows lustreless, and in vivid contrast to itself in health; the oral mucous membrane is seen to be pale; the tongue presents a peculiar and pathognomonic variation known as the "glazed tongue;" —the organ is seen to be flabby, "indented" by the teeth, a furry coating over most of the surface except the edges and tip which are reddened, and in the middle an ovoid patch of glistening surface which looks as if it had been shaved. Here and there about the surface fungiform papillæ, brightly reddened, show strongly through. At times, especially after a stormy period of vomiting and purging, a second appearance comes upon the tongue, which is known by the name of the "worm-eaten appearance." Here the organ is not so flabby, is more of its normal shape, the furring not so extensive, but more uniform and thicker, and the characteristic worm-eaten appearance is an irregular denudation here and there about the surface just like an old, worm-eaten bit of wood, the surface of which is bright red with sharp-cut edges where the coating outlines it.

Curious mental states often prevail during this disorder; exceeding capriciousness of temper, for which the child may be unwisely punished; morbid cravings; absurd fancies which take the color of the child's temperament, with such variations as its accidental training may cause. A characteristic point also is the tympanitic belly which is almost constant about an

hour or two after food; and now and then in the early morning an umbilical colic. Constipation is the rule, and when this is overcome, is very likely to alternate with painful tenesmus.

The nights are periods of horror with unrestful sleep, terrifying dreams, sometimes actual walking expeditions which, in fact, are rarely causeless. The urine may be passed unconsciously. Again, grinding of the teeth at night and the picking of the nose by day, produce a picture which old women gravely insist is due to but one lubricoidal cause. As a matter of fact, worms are rare nowadays, at least in my experience, much more so than formerly. I can distinctly recall the time when it was a common thing to dislodge ascarides, but now it is less frequent although suitable remedies may be applied as tests.

The temperature is rarely disturbed. It may, however, be a little high, especially after undue fatigue, and is, in a certain sense, an index or nerve tire. Another characteristic point is a prevalent irritative cough quite independent of any pulmonary involvement.

*Treatment.*—The treatment is much the same as that of indigestion, except that in indigestion the results are soon obtained, whereas in mucous disease it is imperative to regulate the entire environment and conduct of the child for a much longer period, even for months. The indications are to stop the fermentation of the food, and to give this in regulated amounts and at definite intervals. No starch foods should be taken, except carefully guarded bread. Fresh bread is indigestible because of the continued activity of the ferment. After some hours this ceases to be. Also the subjecting of bread to a second heating kills this ferment and makes it more wholesome. Therefore, a re-heating does nearly as much as toasting without the objectionable effect which toast has upon the bowels. The hours for feeding had best be systematized thus: Breakfast at seven, a light meal or "tiffin" at eleven, dinner at half past two and a light supper again at seven. The food should consist of milk either guarded with a little lime water, or peptonized by the cold process; broiled meats, beef and mutton and rarely a little chicken; soups well-free'd from fat; oysters occasionally; purées of clams, oysters, or fish. The green

vegetables well cooked—such as asparagus, spinach, stewed celery, cauliflower tops with every other day a soft boiled egg for breakfast, or an egg boiled very hard and the yolk spread on bread are suitable. Butter is best omitted, but an excellent substitute is the yolk of a lightly boiled or poached egg spread on bread. It is well to make such variety as is possible by using different kinds of bread,—rusk, rasped rolls, etc. The meats should be well selected, tender, and the fat carefully removed. As the child improves, stewed dried fruit with very little sugar, or a baked apple may vary the monotony, but the best dessert is the innocent preparation known as junket—milk curdled with rennett, calves' foot jelly, or possibly a plain rice pudding.

The clothing should be very carefully inspected—a flannel band about the abdomen to begin with, and *always* wool next to the skin. The outer clothes may be light, especially in warm weather, but the surface of the skin must be protected by a thorough non-conductor, always wool or possibly silk. The skin must be kept in good condition by bathing. In this it is well to use, rather than soap, salt, which is amply cleansing and more stimulating. A second treatment of the skin should be had after the mid-day exercise, in the shape of a rubbing down with a coarse towel, or what is extremely good, a salt towel. This consists of an ordinary crash towel dipped in a strong salt solution and dried. Exercise is important to regulate carefully. Where the child is very weak this should be at first altogether passive by means of massage, either professionally done or at the hands of an ordinary nurse who could easily be taught the simpler movements. Later small increments of exercise may be prescribed, such as are had through the Swedish remedial movements, and, as strength increases, out-door movement in the form of driving interspersed with short walks. After exercise of all kinds, a brief period of absolute rest must be observed—a quarter or a half hour at least. Exercise tends to keep the blood upon the surface and to excite a more active ebb and flow. It also stimulates digestion and works many other advantages, provided always it be judiciously regulated and even supplemented by ample rest.

The medicines are of less importance.

The first indication is to check the output of mucus, the next to neutralize the acids and prevent their formation. The alkalies are useful here, producing several effects, partly sedative and partly aiding to dissolve the mucous mass. Next comes the restoration of the irritable mucous membrane and to bring back the normality of secretion. Here aids to digestion and digestive ferments can be combined. Finally, the bowels need careful regulation. In my dispensary work we use two or three simple prescriptions which seem to be entirely efficacious. The first of these is bicarbonate of soda and infusion of gentian. Curiously enough, children object very little to this nauseous dose and administered before meals it is wonderfully effective. If great objection prevails, a drop of nux vomica to five drops of glycerine, along with the bicarbonate of soda, is better taken. Syrups are to be avoided, and yet the following mixture also has a valuable function. Bicarbonate of soda, nux vomica, spiced syrup of rhubarb and water, make an excellent combination, taken before the three principal meals. The clearing of the bowels, where this is needed, is best done with castor oil, although if the activity of the liver is manifestly impaired, a little calomel may be used with advantage, or the tasteless phosphate of soda, or, again, chloride of ammonium persistently used. To restore intestinal tone, and keep the bowels regularly moving, either myrrh alone, or tincture of myrrh and aloes, serves a useful part. I usually tell my students that the most important agent in treating these disorders of the digestion is a pencil and a good sized sheet of paper. For thus can one write out at length the conduct of the child for the entire twenty-four hours, specifying the hour for medicine, for food and for exercise, the time of bathing, the length of the exercise and the rest, making clear that these shall not be unduly near the feeding time, outlining exactly what foods may be taken and what avoided, and thus alone can the best results be had. I might speak of endless drugs which have, no doubt, their uses, but I think it would be of questionable value.

I close this summary with a few remarks on the preparation of foods for children.

First, of mother's milk. I wish I

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could believe that mother's milk was the best food for a baby. It ought to be but it is not. By this I mean that it so rarely happens that a mother is both a good mother and a first-rate cow, that one stands among the rarities. In the lower walks of life the mother has not only large drains upon her through unavoidable physical labor, but has responsibilities, in the bearing of which variations arise which reflect themselves upon her milk. If she content herself with simply being the mother and caring only for the baby, as in the case of a well-paid wet nurse, that would be quite a different matter. A wet nurse is able to be many times better than a mother. The mothers of the upper walks of life have also many drains upon them, chiefly emotional, and they, too, fail many times, but not necessarily oftener than the poorer ones, although the contrary notion prevails. The wet nurse, theoretically the best supply of food for a baby, is seldom much better than is careful hand-feeding. So, when all is said and done, thoroughly careful hand-feeding is about the safest and most reliable.

When the milk of an animal is the aliment, much care is needed from the time it is removed from the cow until it is used by the child. Two or three practical points may not be amiss. Milk from a healthy cow may be used instantly it is drawn or else not until it has been subjected to a primary chill. It contains certain volatile principles which, if not removed, are partly poisonous. After being drawn, milk should instantly be placed in a temperature of 60 or 65 degrees, in a clean atmosphere free from all objectionable odors, and there allowed to remain until quite cool. Thus are the gaseous principles expelled from it and in other ways it is rendered more wholesome. When received by the consumer, it should be put carefully in an hermetically sealed vessel and in a cool place, not necessarily the refrigerator, which usually contains butcher's meat or other materials which may give forth offensive smells, but kept apart by itself, if merely placed in the shade where a good draft blows, and it is cool as in an ordinary cellar. In very hot weather it is well at times to employ sterilization, but this should never be continued any length of time, because sterilized milk does not maintain the health, nor is

it competent to form the best of muscle and other structures. Under conditions of stress, pasteurization is usually sufficient.

*Variety.* No matter how judiciously a child with weak digestion be fed and how admirably the regimen outlined seems adapted to his needs there comes a time when he needs change and variety. As the changes in the digestive capacity grow rapidly in the earliest years, care must be exercised to liberalize the dietary consistent with the constitutional demands. A typical illustration of this came under my notice at Bar Harbor last summer. The child, aged three years, of a gentleman who was himself a patient of mine had been ill and was carefully directed by a physician of the highest ability to live on a prescribed diet and throve abundantly. This was continued for many months with unvarying regularity. After a time for no discernable cause the boy failed, grew irritable, seemed weak, easily tired; began to void uric acid, the skin grew flabby and leaky. The change of air had done nothing for him and the parents were in despair. A careful search into the matter revealed the wretched lameness of a diet suitable to a child of a year younger and consisted of milk, soups an egg alternate days and zweibach; varied only with junket and rice pudding. In the face of the morbid fears I enlarged this by the addition of a few green vegetables, roast and broiled meat once daily, a little fish and some stewed fruit and promptly the whole picture changed.

**Palpitation.**

Examination Physician of Insurance Company—What did your father die of?

“ Palpitation ohf der heart.”

Physician—Mother?

“ Palpitation ohf der heart.”

Physician—Two brothers?

“ Palpitation ohf der heart.”

Physician—What Caused it?

“ Dhey each bought a lottery ticket and missed der big prize.”

JUSTICE.—“ Officer what is the prisoner charged with?” Officer Lafferty—“ Well, your honor, I'm not a judge, but it smells to me a good deal like whiskey.”—*Exchange.*

**CLINICAL LECTURES.****HEART STRAIN, PROPHYLAXIS AND TREATMENT.\***

CHAS. G. STOCKTON, M. D.†

In speaking of typhoid fever, I have told you that one of the most important matters to be borne in mind concerning convalescence is the condition of the heart. Many persons who recover from typhoid fever are hampered with weak hearts, and it is our duty always to examine carefully into this point and not to allow patients to return to work until we are certain that their hearts have regained fair strength.

This patient came early in January. His case was one of "walking typhoid"—probably in the third week. At the time of his admission to the hospital he had a temperature ranging between 103° and 105°, and continuing thereabouts for three weeks longer. Before his fever had disappeared his heart was found to be weak. It was stimulated with large doses of brandy, digitalis and strychnine, but, at certain times, it seemed impossible to keep it beating. In the latter part of February his pulse was 40 to the minute, very weak, intermittent and irregular. A little later the pulse fell to 35. For two weeks it ranged between 60 and 30, and at one time it fell to 18. The sounds were indistinct and it was almost impossible to feel the pulse at the wrist. It was only by the use of heat and friction to stimulate the capillary circulation and by the internal administration of liberal doses of heart stimulants that the patient was kept alive.

Under steady stimulation the pulse has been restored nearly to normal and is now beating at the rate of 60 or 75 to the minute, while the heart sounds are fairly good. This man, however, will have a weak heart for a year at the best, and, during that year, he should not be allowed to engage in hard work. If he does he will become one of the unfortunate individuals, and there are many such, who

go through life with strained hearts.

Another patient, who comes to me from Pennsylvania, is a woodsman, engaged in lumbering and other forms of active exercise which should make him strong and vigorous. At the same time, however, he has overstrained his heart, and, as a result, it has not been able to fulfill the demand which the body has made upon it. In spite of tonics and general treatment which various physicians in Pennsylvania have given him, he has suffered from vague symptoms of weakness and discomfort without really knowing what was wrong with him.

On admission to the hospital, his heart was slow and weak, its first sound almost inaudible, and there was a general weakness without signs of other organic diseases. I put him to bed and have kept him there, allowing him to get up now only for the special occasion of appearing before you. He has had heart tonics, digitalis, strophanthus and, especially, strychnine.

If I could do for him exactly what I should like, he would be kept on his back for two or three months with faradism every day, with massage, friction and hot footbaths to bring the blood to the surface of the body and stimulate the capillary circulation. The same plan of treatment should be resorted to in this first case of convalescence from typhoid fever, if the heart does not return to its normal condition; for, although this heart has not been strained, it is weak following the cloudy swelling and fatty degeneration that so commonly occurs in severe infectious diseases.

Overwork, loss of sleep, long watching, grief, excitement, may bring about strain to a perfectly normal heart and after a long siege of typhoid fever, there is often harm done in allowing a man to go back to his routine work, which usually means the necessity of overdoing and of overstraining an already weak and susceptible organ.

\*Delivered at the Buffalo Co. General Hospital.

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This third case is also one of convalescence from typhoid fever. The patient was admitted January 5, in the beginning of the disease. He was very ill and his temperature ranged from 105° to 106° in the evening, requiring antipyretic measures. His pulse varied from 130 to 140. Finally both temperature and pulse fell, the latter reaching 60, 50, 40 and even 30 to the minute. His heart was sustained when not too infrequent by digitalis and strophanthus and when it became too slow to admit of the use of such drugs, by strychnine hypodermatically, the largest doses being, gr. one-twentieth, often enough to keep the heart going.

This man, as well as the first patient, came near dying from syncope. He was at times unconscious and his extremities were cold. His stomach was intolerant for a time, and he was nourished by rectal alimentation. The condition of debility was relieved by rubbing with alcohol, by hot mustard footbaths and by various

internal stimulants. But his heart will remain weak for a long time and he must be advised against active work.

It should be observed that this cardiac depression is far less frequent in those patients who have had the benefit of the cold water treatment as directed by Brand, of Stettin.

There is one other point about which we must be cautious in these cases of convalescence from typhoid fever. We must be sure that the patient does not pass from our hands with the alcohol habit fixed upon him. The use of alcohol has been unavoidable during the course of the disease, and you will readily understand how a patient with a weak heart is much more predisposed to keep up the use of alcohol than is a healthy individual. A man whose heart is so weak that it is impossible for him to exercise either mentally or physically with comfort unless he is sustained by alcoholic drinks, is very prone to form the habit of taking whiskey.

## COMMUNICATIONS.

## THE ADVANTAGES OF ANTISEPTIC IRRIGATION OF THE PARTURIENT CANAL BEFORE AND AFTER LABOR.

T. RIDGWAY BARKER M. D.

"To avoid danger is a thousand times better than to prepare to meet it."

Prompted and emboldened by this thought, I present for consideration and discussion the advantages to be gained by the employment of ante-partum and post-partum vaginal irrigation.

Having accepted as proven the role which micro-organisms and their products, ptomaines, play in the development of disease, it has been my practice for the past two years to employ, in cases of confinement, irrigation of the parturient canal.

The results from this routine method have been so uniformly satisfactory, aside from any theoretical considerations, that I would fain persuade every practitioner of obstetrics to give the plan an impartial trial.

While it has, I am well aware no definite

claims to novelty, yet the rules governing aseptic midwifery are so generally disregarded in private practice that further study cannot be otherwise than beneficial.

It is certainly a fact that strong antiseptic solutions containing mercury or carbolic acid are likely, and will, if long continued, poison the patient. Garrigues, in his paper on "Corrosive Sublimate and Creolin," published in *The American Journal of the Medical Sciences*, 1889, reports twenty cases of death from this drug in obstetrical practice. But any valuable remedy will fail to give good results if not properly administered. Therefore, its abuse cannot be said, in any way to militate against its use.

The method which has given me the best results consists in having the external parts about the genital region carefully and thoroughly scrubbed with soap and

hot water with the onset of true pains. This is followed by a second cleansing with 1 to 1000 bichloride of mercury solution, the final washing being with boiled water. This completes the toilet of the entrance to the vestibule of the birth canal. As to the treatment of the canal itself, a fountain syringe is filled with one quart of hot, boiled water containing bichloride of mercury 1 to 5000. The ordinary nozzle made for vaginal use, after being rendered aseptic, is introduced into the vagina and carried up to the anterior vault of the canal, the stream of water having been running freely before introduction, to expel all air from the tube. When about half the solution has been used in bathing this portion of the vagina the nozzle is slightly withdrawn and made to enter the posterior pouch. In this way the whole mucous surface is irrigated, and at the same time some of the overflow bathes the cervix.

It is very desirable to finish this step in the procedure before rupture of the membranes, as their presence tends to prevent the escape of the antiseptic fluid into the uterine cavity and between the uterine wall and decidua. It will be noticed that so far our ante-partum efforts at cleanliness have been principally confined to the vagina, and this is the point to which our attention should be principally directed, for the source of infection is far more likely to lurk here than in the pregnant uterus.

The vaginal douches are to be administered with the female in the semi-recumbent posture, in order that free drainage may be secured and no fluid permitted to collect behind the posterior margin of the vulva. The antiseptic irrigation is to be followed by a free bathing of the parts with boiled water, so that absorption of the mercury may be rendered impossible. By these means we run no risk of mineral poisoning, while we do secure a perfectly aseptic condition of the birth canal.

When can we, without such precautions say, with any degree of certainty, this woman's birth-canal contains no gonococci or other noxious germs? Her family life may have been the purest in every particular, yet gonococci may be present. The occupation of the husband, as Lapthorn Smith, of Montreal, has pointed out, through a lack of personal cleanliness may infect his wife. Such oc-

cupations as scavenging, rag-picking, and the like, render a man especially liable to infection when the simplest rules of hygiene are neglected. The same author pertinently remarks, "Before labor begins we should disinfect the vagina of all women whose husbands have had gonorrhœa, taking it for granted that all have had it unless we have proof to the contrary."

Some writers, in spite of such facts, declare antiseptic irrigation unnecessary, because, they argue, that Doderlein's experiments, as to the nature of the micro-organisms found in the healthy vaginal canal, prove conclusively that they are non-pathogenic; but I would make answer, that what is harmless in a healthy vagina with a perfect mucous membrane is not necessarily so when its walls have been overstretched and are the seat of lacerations. The science of bacteriology has not yet declared the law that non-pathogenic micro-organisms always remain so under all conditions and circumstances.

Among those who are opposed to such prophylactic measures as I have suggested, may be mentioned Rosenberg, of the New York Polyclinic, who states in a paper published in the *Medical Record*, February 4, 1893—"So far I have not said anything about the prophylactic vaginal douches, and I only wish to speak about them to condemn their routine administration. I do not believe that the vagina can be made sterile, no matter how much douching is done; but I do believe that infectious material is very frequently carried into the genital tract by dirty instruments or fingers."

Now it goes without saying, that if you are going to employ dirty instruments and fingers in your pseudo attempts at aseptic midwifery, you had far better avoid examining the patient at all. In fact, it would be wiser to secure some one else to take charge of the case. Therefore, such an argument is fallacious.

But what is still more surprising is that the same writer in his article, should cite, in support of this view, several cases of puerperal infection in which the women died. They were supposed to have aseptic parturient canals, when in reality septic matter had been introduced by unclean midwives in their efforts to ascertain the female's condition previous to the arrival of the medical attendant.

Here we have a striking example of our inability to distinguish between an aseptic and a septic birth-canal. The life of the woman is thus risked unwarrantably when we have nothing but pure assumption on which to base our opinion.

Some extremists have gone so far as to recommend the employment of vaginal antiseptic injections as early as one week, or more, before the onset of labor, and they advise continuing them until the first stage is well advanced.

This is, perhaps, carrying the principal of antisepsis too far, but better than not far enough. The importance of having an absolutely clean nozzle to the syringe, cannot be too forcibly impressed. Dirty tools can never be expected to do clean work.

Earle, in a paper published in the Chicago *Medical Journal and Examiner*, tersely remarks, "You cannot carry out intra-uterine injections with a half-ounce syringe and a goose-quill." Were the benefits arising from vaginal irrigation previous to delivery wholly included under the term asepsis, we might rest well-satisfied, but that is not all, for the hot fluid fills a useful purpose in softening the cervix, thereby lessening the pain incident to its dilatation.

Some may urge against the practice, that it washes away the natural mucous secretion which is intended to lubricate the parts and facilitate the passage of the infant, but this is a theoretical objection which has no existence in fact. Quite the reverse one finds to be the case, which is confirmed by Garrigues, of the New York Maternity, who states, in a paper read before the Section on Obstetrics and Gynecology, in 1892: "Personally, I am opposed to rubbing and scrubbing the vagina, as some think necessary, but as to a vaginal injection before delivery, I believe yet, that it is useful. It will remove both dirt and microbes, and if, at the same time it removes a layer of mucus that lubricates the vagina, and, therefore, protects the perineum, it is easy to see that new mucus is poured out in abundance to replace the first."

With an aseptic parturient canal our fears of infection of the eyes of the infant, as it is driven along, are practically nil, for there is nothing to give rise to ophthalmia, that terrible disease so fatal to the sight. As my paper does concern

itself with other necessary precautions, such as those relating to the clothing and the person of physician, nurse, and patient, no mention will here be made of them.

Having outlined the ante-partum procedure which would seem to recommend itself to the careful accoucheur, we have still for consideration some post-partum measures.

Whether the case has been one of natural or instrumental labor makes no difference, all must be treated alike, save the latter class will require extra care and attention, since the doors for the entrance of septic matter are more numerous and wider open.

No matter how skillfully one may have delivered the placenta and secundines, we never can know positively whether everything has been expelled. Let the examination of the placenta be ever so minute, a fragment may be left behind, or a shred of membrane that the eye of the attendant has failed to note the absence of.

Appreciating this fact, it is but fair to assume that there is in every uterus after delivery, a cavity which contains material which, if it becomes infected, will place the patient in great danger. Micro-organisms feed on dead tissue, and by their multiplication pour out ptomaines which, when brought into contact with living cells, cause their death.

Thus is formed the virulent poison which the vessels are ready to suck up and carry through the system. Let the source of the pathogenic organism be what it may, we do know that when it takes up its residence in the utero-vaginal canal it is a terrible enemy to do battle with. Therefore, it would seem but reasonable to institute prophylactic measures to prevent the entrance and development of these breeders of disease, which can best be accomplished by the employment of antiseptic irrigation.

Mercury in the form of corrosive sublimate is scarcely suitable for post-partum vaginal irrigation, since it is so readily absorbed by abraded surfaces. Hence, carbolic acid, creolin, boric acid or peroxide of hydrogen are to be preferred. The advisability of resorting to irrigation immediately after labor is questionable, since the likelihood of inducing hemorrhage, introducing air, or irritating fluid

into the yet unsealed uterine sinuses is possible.

After the lapse of twenty-four hours, however, I would recommend a vaginal douche of carbolic acid, one drachm to the pint, or creolin, one per cent., followed by an equal quantity of boiled water.

It would appear from the clinical symptoms of puerperal infection, that the first manifestations occur on the third or fourth day, in other words, the lochial discharge in the first twelve hours is so free that no contamination by micro-organisms is possible, but on the second day, the discharge not being so abundant, the germs gain a footing, and after a lapse of twenty-four hours pour sufficient poison into the blood-stream to jeopardize the life of the female.

Earle quotes Bakelmann, as deeming intra-uterine injections indicated when, forty-eight hours after birth, the temperature rises to 101.5°F. to 102.2°F., with frequent pulse, without a recognizable cause for it; also, when fragments of placenta and membranes remain in the uterus as a cause for disturbance, and when symptoms of infection of the endometrium are present.

Of course he does! Who would not under such circumstances? But where is the wisdom of waiting until these disintegrating masses become infected before bringing about their expulsion? Why, indeed, delay in removing the oil-can, so to speak, from the neighborhood of the fire when experience unmistakably teaches us that it will explode if only left there long

enough? Let us, at least, be reasonable and hasten with all judiciousness to place beyond reach the dangerous element.

If our knowledge of septic processes is worth anything, it surely ought to convince us that disintegrating organic matter has no place beside the living, and the wider the range of separation the safer for the individual. When we resort to vaginal irrigation at the expiration of twenty-four hours, we find the canal in a condition suitable for such a procedure. If the amount of carbolic acid does not exceed one drachm to the pint of warm water, and free drainage is secured, surely no poisoning is possible. Too much stress cannot be laid on the importance of having the female occupy a semi-recumbent position so that the escaping fluid may tend to gravitate toward the patent vulvar orifice. The pressure by which the solution is forced into the passage should be as low as possible, the object being to irrigate rather than inject.

As is well known, when the woman lies on her back the discharges accumulate at the posterior and inferior portion of the vagina and form a pond well-suited to become the feeding ground for pathogenic organisms. By destroying this nest, which antiseptic irrigation accomplishes, we stop the production of ptomaines and relieve the system of further danger from infection. Appreciating, therefore, the great advantages and the increased safety to the parturient, can we do better than adopt for our motto in obstetrics, and carry out in practice—"CLEANLINESS FIRST, LAST, AND ALL THE TIME."

#### FRACTURE OF SCAPULA FROM MUSCULAR ACTION.

P. V. HOOVER, M. D., BOONVILLE, IND.

Mr. G. T., ~~st.~~ 30 years, who while scuffling with a man that was about forty or fifty pounds heavier received a fracture through the body of the right scapula. He said he threw his antagonist over his shoulder his hold suddenly breaking; and as the muscles relaxed he felt something give way on the posterior portion of shoulder. Physical examination revealed marked crepitus through body of scapula.

I applied a pad over scapula and held it in position with the usual dressing. Union was rapid and perfect, and there has been no inconvenience since.

I have related the case to a number of physicians and surgeons, and they have all told me that they had never heard of a like case. I therefore report it thinking that its rarity might make it interesting.

## SOCIETY REPORTS.

## THE CLINICAL SOCIETY, OF LOUISVILLE.

Stated Meeting April 4, 1893.

THE PRESIDENT, Dr. I. N. Bloom in  
the Chair.

## TUMOR OF THE BREAST.

DR. W. O. ROBERTS: I have had a run on malignant diseases of the breast in the last week, having had four cases, the last of which was operated upon to-day, all of them being patients sixty years of age. The tumor removed to-day was first noticed three years ago. Some two months before the lump was detected the lady had a fall, striking her breast against a chair, which gave her very little pain, still she seems to attribute the trouble to that blow. She tells me that the breast a year ago was very much larger than at the time of its removal to-day. It has given her a great deal of pain. No enlargement of the glands in the axilla could be detected prior to operation, but after the space was opened I found two glands that were about as large as a hazel nut. It has all the characteristics of scirrhus—retraction of the nipple and hard, indurated feel of the tumor—and it will be seen upon examination that the muscle seems to have become involved in the growth, the muscle drawn up, as it were, into the tumor. The greater part of the pectoralis major muscle was removed and the axilla thoroughly cleaned out, not only all the glands, but all fatty tissue, leaving the vessels and nerves exposed.

## DISCUSSION.

DR. J. M. MATHEWS: Do you ever remove the glands in the axilla unless you can feel that they are indurated or enlarged?

DR. W. O. ROBERTS: I take them out always. Unless this is done I think the operation does not hold out much to the patient, and recurrence is apt to take place quickly.

DR. J. M. MATHEWS: The reason I asked the question is that I have seen quite a number of operations for excision of the breast where the operators paid no attention to the glands of the axilla un-

less an enlargement can be felt.

TWIN PREGNANCY—DEATH OF ONE FETUS  
AT FOUR MONTHS, THE OTHER  
BORN ALIVE.

DR. J. M. KRIM: Twelve days ago I was called to attend Mrs. T. in her third confinement. The history of the case is that she gave birth to twins the first time, second time single and this time when I was called she said she had "about three weeks to go." I made an examination and found her in the first stage of labor; I remained seven hours, I think, and the child was born matured but rather small, weighing about 6½ pounds. A few days afterward I was telephoned to return at once as the patient was suffering with terrific pain; I went back, made an examination, and found protruding through the os something soft, after making slight traction, it ruptured and a very foetid substance came away shortly afterward which proved to be a macerated fetus at about the fourth month. The uterus was thoroughly doused and cleansed out, and the patient made an uninterrupted recovery.

The reason I report the case is to get the opinion of the society as to whether this was a twin pregnancy, or a subsequent pregnant condition. The child delivered on my first visit is still alive, apparently not fully grown, was about the eighth month. The fluid which came away on my second visit seemed to be perfectly clear but had a very foetid odor.

## DISCUSSION.

DR. I. N. BLOOM: How long had the patient been married and what were the intervals between the various pregnancies?

DR. J. M. KRIM: Married eight years. First delivery fifteen months after marriage; second four years after the first, this being the third which is about three years after the second.

DR. D. P. SATTERWHITE: I do not think there can be any doubt but both

impregnations occurred during one coition. It is proven according to Gaston that there are never true twins unless they are enveloped in the same sac.

DR. W. O. ROBERTS: Do you know if there was at any time during pregnancy any uterine hemorrhage?

DR. J. M. KRAM: This patient belongs to the working class, and said that one time while sweeping she felt a peculiar pain which lasted probably two or three hours; after that she felt nothing more of it. She said, of course, that she felt some pain occasionally, but attributed it to the condition she was in as she had noticed the same pains in previous pregnancies.

I am of the opinion it was a twin pregnancy, two placentas, but why one ceased to grow at four months and the other go on to nearly full term, I am unable to say.

#### EPICYSTOTOMY FOR REMOVAL OF CATHETER FROM THE BLADDER.

DR. W. O. ROBERTS: I performed an epicystotomy week before last on a man sixty-five years of age; the history was that he had some trouble in passing urine and had to occasionally use the catheter to empty the bladder. He was a hard drinking man and three weeks before I saw him he had occasion to use the catheter which he said had not been necessary for some months before, and after introducing it into the bladder it broke off. He said it was one of those red rubber instruments and he was in hopes that he would be able to pass the piece that was left in the bladder, but this did not occur. Violent cystitis developed and his physician consulted me on the subject. I told him the only thing to do was to perform a cystotomy and remove the portion of catheter. The patient came here and I intended keeping him in the infirmary for a few days to prepare him for the operation, but he said he would remain at the hotel until the preliminary treatment had been carried out. In the afternoon (Tuesday) I went to the hotel and found that the patient had gone to the infirmary; when his son had come to my office to consult me about the operation, the old gentleman had gotten on a big spree, and the boy took him immediately to the infirmary. Tuesday evening he was very drunk; Wednes-

day he sobered up and we managed to keep him in the house until the next day when I operated. I removed from his bladder two pieces of catheter, one about two inches and the other one inch in length, and each piece was heavily coated with salts from the urine—I suppose the coating was at least  $\frac{1}{8}$  of an inch in thickness. They were not broken in the attempt to remove the fragments during operation, because they were entirely covered with this coating, showing that there were originally two pieces in the bladder. The technique of the operation was about this: A rubber bag was introduced into the rectum and distended with air, then the bladder was filled with air, then the bladder was filled with water—I say filled, eight ounces being put into it—then an incision made and bladder opened. The incision was made a little too low; I got in front of the point where I wanted to open the bladder and went into the upper wall of the prostate. I recognized this fact simply by the considerable amount of hemorrhage at the time. I carried my incision into the bladder, removing the two pieces of catheter and the man recovered without an untoward symptom, and without the slightest elevation of temperature. He was up on the sixth day sitting in a chair. He now spends most of his time sitting at the window in his room at the infirmary.

#### DISCUSSION.

DR. I. N. BLOOM: How did you treat the bladder wound afterward?

DR. W. O. ROBERTS: After removing the catheter I washed the bladder out very thoroughly with hot boric acid solution then introduced a strip of iodoform gauze draining the bladder in that way for twenty-four hours, then took the gauze out. Did not use any sutures in the bladder at all, or in fact anywhere.

DR. I. N. BLOOM: I was connected with a case of epicystotomy a few days ago in the role of consultant, another gentleman doing the operation. Dr. Schachner asked me to see a case in consultation, the patient giving unmistakable clinical history of stone. He had not up to that time sounded for stone, and I advised that this be done, feeling sure that we would find one. This proved to be the case and I was asked to be present at the operation for its removal. He did an

epicystotomy very neatly and dextrously; there was no hemorrhage. He used the colpeurynter, distending the rectum with about eight ounces of water; there was no trouble with the peritoneum; the stone removed was phosphatic, oval in shape and weighed one ounce two grains. The after treatment differed from the method mentioned by Dr. Roberts: He sutured the bladder; by the way I do not think it is ever possible to select the muscular coat and be absolutely certain that you have not included some portion of the mucous coat. In closing the external wound he left a glass drainage tube in the lower angle for a day, and leaving a permanent catheter inserted for forty-eight hours. The patient did uninterruptedly well. The only difference in technique of the operation between the two was the after treatment. I ask for information and would like to know why Dr. Roberts used the method he spoke of, the open treatment without stitching the bladder.

**DR. W. O. ROBERTS:** I preferred it because the man had cystitis; the principal object in the open treatment was to get rid of the cystitis.

#### STRICTURE OF THE OESOPHAGUS.

A man twenty-eight years of age, who had typhoid fever in December, was given permission by his physician to eat solid food on the third of February last. He had a chicken cooked but when he made the attempt to eat it, he found that he was unable to swallow. He was brought to me the other day and I believe he has a complete stricture of the oesophagus. I did not use the oesophageal tube to see whether or not it could be passed, but his physician told me a little over four weeks ago he passed a tube into the stomach and the patient then attempted to pass it himself, but it bled so considerably he desisted. I examined him as carefully as I could and could detect no evidence of any tumor or any trouble with the heart or aorta producing pressure upon the oesophagus interfering with deglutition in this way, and had him taken to the infirmary; shortly after going there he began to improve, was able to take milk without any trouble, and I took it that the stricture was due to some local or reflex trouble that would pass away, but for the last three days he has been unable to swallow

anything at all and is running down. I would like to know if any Fellow has ever met with a similar case.

#### DISCUSSION.

**DR. P. GUNTERMAN:** I saw a case reported in the *New York Medicinische Monatschrift* where a very similar state of affairs existed after convalescence from typhoid fever; the patient suddenly was unable to swallow. A tumor was detected however causing complete closure of the oesophagus and in a very little while the man died. A post mortem was held revealing a little typhoid fever ulcer in the oesophagus which let fluid enter in between it and the trachea, closing up the oesophagus and trachea. There may have been something of this kind in the case reported by Dr. Roberts.

**DR. P. GUNTERMAN** read a paper (see page 806 issue of May 27) on  
**CHLOROFORM ANÆSTHESIA AND ITS ADMINISTRATION.**

#### DISCUSSION.

**DR. L. S. McMURTRY:** In the consideration of this important subject one question deserves special attention, viz., Who should administer anæsthetics? Generally speaking, every physician ought to be qualified to administer anæsthetics, and in obstetrical practice anæsthetics are given with impunity and safety without any special skill. When we consider the daily frequency with which anæsthetics are used in skilled and unskilled hands and under all varieties of conditions and complications, it is remarkable that so few accidents occur. But there is something more in administering anæsthetics than procuring respite from pain without the immediate death of the patient. Anæsthetics can do serious damage in surgical cases without producing death. Prolonged and profound saturation with anæsthetics is often the cause of death after surgical operations which are classified as deaths from shock. I do not believe we can too strongly emphasize the responsibility of the anæsthetist in surgical work. That is a position of the highest responsibility and requires judgment, care and skill, and since the operator assumes all responsibility it is a position of high trust. The duty of an anæsthetist should be entrusted only to those who have learned how to administer these agents, and who realize the responsibility. In this, as in other

features of surgical work, much of success depends upon attention to details. Fright is of itself an element of danger in anaesthesia. The anaesthetist should be introduced to the patient and establish confidence and give assurance. The operation, however trivial, should not be begun until anaesthesia is produced; by this I mean insensibility to pain. And then a certain degree of anaesthesia should be maintained, using the smallest quantity of the drug possible to attain this condition.

My friend, Dr. Kynett, of Philadelphia, who has had an exceptionally rich experience with anaesthetics, has called attention to a valuable sign of the danger line in anaesthesia: When the addition of fresh ether to the cone fails to produce an up-and-down movement of the wind-pipe the ether should be withdrawn; when that movement occurs, the condition is a safe one.

**DR. J. W. GUEST (Visiting):** I have listened with a great deal of interest to the paper read, and heartily indorse it in substance. I have found from my personal experience, however, four points in which I would slightly differ with the essayist.

1st. I believe that the stomach should be entirely empty if possible, at the time the anaesthetic is administered. Of course if there be nothing practically in the stomach that much less will the vomiting be.

2nd. In regard to watching the respiration: In giving chloroform about four hundred times, I have had eight accidents or seven accidents and one death; and I have noticed that the circulation and not the respiration was the first to disappear.

3rd. Concerning the cone: I formerly used the towel and paper cone, but in the last one hundred cases I have employed the Esmarch cone and bottle which I think is decidedly the best and safest cone that I have ever seen.

4th. I find that those patients who fear chloroform most usually take it best.

**DR. J. M. MATHEWS:** I suppose I am recognized as a chloroformist, because I believe honestly in the administration of chloroform in preference to ether. I have never had an accident or a failure in administering it; I do not know how often I have given it, but would say between two or three thousand times since I began the practice of medicine. I have administered it four times to-day.

One of the greatest points of interest to be discussed in this matter is, which is the safest anaesthetic of the two? And this is the reason I suggested that we be allowed to mention these points. I believe that if you will take your patients indiscriminately and treat them as physicians usually treat them; that is, without paying attention to the points brought out by Dr. Gunterman, it can be demonstrated that chloroform is the safest anaesthetic. Dr. Gunterman very properly says that the heart should be examined,—he should also have added that the urine should be examined; but who does it?

If you will permit me to say in this connection, it has not been many months since I saw in consultation with one of our most eminent physicians a case in which it was decided to do an operation, and this physician said, for safety we will give him ether. It was understood that he would make an examination of the urine prior to administration of the anaesthetic, but he failed to do so. Reaching the place where the patient was, and having no ether, we decided to give chloroform. An analysis of the urine was made afterwards and it was found to contain a very large percentage of albumen. The patient died in less than six months with albuminuria. We gave him chloroform; could we have given him ether safely?

I believe, therefore, if you will take the patients as they come, hospital dispensary and private, recognizing how common diseases of the kidney, etc. are, that we have the safest anaesthetic in chloroform.

Under the first proposition of the essayist, as to who can take chloroform? There is a medico-legal point involved. The law holds the physician responsible for deaths from anaesthesia if he is derelict in his duty, and this is done upon the idea that the physician should make an examination of the patient before he gives the anaesthetic. In other words, it is presumed we know why patients die from anaesthesia. I doubt if we do. Such able physicians as McBurney and McLane have stated that they believed oedema of the lungs caused the death of Col. Shephard. I have heard it hinted at least by physicians here, and there is a doubt expressed even in their own report, whether that was the case or not. The question without a post mortem cannot be settled, whether for instance this man had any

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serious kidney trouble, and that was the cause of his death. While it is stated that they made an examination of the urine formerly, from my reading of the case I infer they had not done so recently.

As to who can take chloroform, I must confess that I have given it in heart trouble, where there was organic disease; I have given it where there was organic disease of the kidney; I have given it to exceedingly highly nervous women—and I want to say in this connection that I perfectly agree with Dr. Guest that nervous, hysterical women take chloroform better than anybody else. In other words those who dread the anaesthetic, those of highly sensitive natures go quickly under its influence and have less trouble than any other class of people. I do not believe we can tell by looking at a patient how he is going to take chloroform. It has been my personal observation that fat large men take a less amount of chloroform than small or delicate men. A member of this society will remember a case where a man weighing fully two hundred pounds was thoroughly anaesthetized by one whiff of chloroform, and remained so for twenty or thirty minutes.

As to the signs evidenced that a person is under the effect of the anaesthetic—Bilroth, in his clinic, proposes the method of having the patient count from one to as many as he can, and when he ceases counting, he says he is ready for operation. I have tested this and believe it a good plan. I have seen many cases where the pupil failed to be a good guide. My habit has been, (and I believe it is a good one) to lift the arm and ask the patient to hold it in that position; as long as he does so, or so long as there is an effort made in that direction, he is not ready, but when the arm drops he is ready for the operation. I believe I have never known this to fail.

In regard to stertorous breathing—Dr. Gunterman has very properly said that when this occurs, chloroform should be immediately stopped. He also says any effort at vomiting, an attack of nausea, should be an indication for ceasing the administration of chloroform—if this were done in all cases you would be unable to operate many times.

As to the method of giving chloroform: I believe it is the consensus of opinion

that chloroform should be given rapidly and yet carefully. I dislike very much to have an assistant who seems to be afraid of giving too much chloroform, and gives too little. I am satisfied that deaths do occur in the manner spoken of by Dr. McMurtry, under partial anaesthesia. So thoroughly am I convinced of this that I will not touch the rectum to do a surgical operation until the patient is profoundly under the influence of the anaesthetic; not even to stretch the sphincter muscle. There are many points that might be brought out in this discussion. What we know about chloroform comes more from ones experience and observation. Those that have been in the habit of giving chloroform without accident will prefer it, the same can be said of ether.

**DR. GEO. W. GRIFFITHS:** I am in favor of chloroform to the entire exclusion of ether. I have seen chloroform administered at Shiloh, Chickamauga, Stone River, Perryville, in hundreds of cases, all sorts of men with all sorts of injuries, and in all that time—in fact in all my experience extending over a period of more than twenty-five years—I have never seen but one death and that occurred at the first battle at Green River, in 1861. I do not believe in the use of a cone, I think the chloroform should be used on a napkin and given in this way it lessens the danger as it is by this method that it is better mixed with the atmospheric air.

**DR. T. P. SATTERWHITE:** I prefer chloroform to ether. One of the most objectionable features of ether is the sensation of suffocation. I believe in the administration of chloroform, but think a man ought to administer it very cautiously. I agree with what Dr. Griffiths has said with regard to the admixture of atmospheric air with the chloroform. I differ with Dr. Gunterman in this particular, that in the stage of excitement which we often have in the administration of chloroform, during this period I push the chloroform more vigorously than at any other time. I would like to say with regard to what Dr. McMurtry alluded to, and which I supposed every member of the society knew, the universal custom is that the anaesthetist shall make a charge for his services. I would not think of asking a man to administer an anaesthetic without expecting him to make a charge.

In nine-tenths of the surgical operations the anæsthetist has the most responsible position.

**DR. I. N. BLOOM:** It is largely a question of locality as to the preference for ether or chloroform. In Boston, and with those people who have gone there to complete their medical education, ether is used almost exclusively. In the south and west for some years chloroform has been employed universally. I think anyone who reads the journals will see the tendency toward returning to ether; an increase of ether advocates. In New York it is about evenly divided and apparently remains in *status quo*. It is claimed—I received my education in Boston—that the mortality in a given number of cases, say in possibly 100,000 cases, was less from ether than from chloroform. I know that this is the principal reason why ether is advocated by those who teach the use of anæsthetics in surgery in Harvard College. Now I also know that there is no

strong advocate of chloroform who does not maintain that the mortality is less from chloroform. I do not think any of us here are competent to judge. I think there is only one way of demonstrating this and that is to take the first 100,000 cases or even a greater number of cases and following up the mortality, and even then it is not satisfactory. A man may have a death from imperfect knowledge of the method of administering, or as has been suggested very properly by Dr. Mc Murtry, by incomplete anæsthesia. I do not think any discussion among a few men will convince either side as to which is the better anæsthetic to use, and I believe it is like the discussion of a political question "when it is finished you are unchanged in your opinion."

**DR. P. GUNTERMAN:** I simply wish to remark that in my paper thus far nothing whatever was said with reference to ether, although the discussion seems to have branched off in that direction.

## CORRESPONDENCE.

### ELEVENTH INTERNATIONAL MEDICAL CONGRESS.

**EDITOR MEDICAL AND SURGICAL REPORTER:**—I beg to inform you, and your readers and exchanges through you, that there is *no foundation* in the rumors referring to a postponement of the Eleventh International Medical Congress, such is the information conveyed to me in a letter of the Secretary General's dated Genoa, May 15th.

It is officially announced, that part of the 15th Section of the Congress will be dedicated to the exclusive consideration of Cholera and Quarantine. Professors Cunningham and Koch are expected to participate in the proceedings of this Sub-section.

Beside the North German Lloyd, the Hamburg American Packet Co. and the Campagnie Générale Transatlantique—the Netherland-American Steam Navigation Company (39 Broadway N. Y.) offers reduced rates to visitors of the Congress. The Hamburg American Packet Co. writes

to say that the families of members are entitled to all the reductions.

Very respectfully yours  
A. JACOBI.

New York, May 28, 1893.

A clergyman, one hot Sunday, observing a deacon asleep in church, called out: "Brother Austin, please open the window a little. Physicians say it is unhealthy to sleep in a hot room."—*Quincy Journal*.

Small Boy—"Papa, what are roosters?"

Father—"Gentlemen hens, my son."

Small Boy—"Do they lay eggs or hatch chickens?"

Father—"No."

Small Boy (meditatively)—"Only hens and ladies hatch chickens and children, consequently I won't have the anxiety of hatching children."—*Ex.*

# THE MEDICAL AND SURGICAL REPORTER

ISSUED EVERY SATURDAY

ADDRESS

Care P. O. Box 843, Philadelphia.

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Editor.

RODERIC C. PENFIELD,  
Publisher.

316 - 18 - 20 North Broad Street,  
PHILADELPHIA.

**TERMS:**—Five Dollars a year, strictly in advance, unless otherwise specifically agreed upon. Sent three months on trial for \$1.00.

**REMITTANCES** should be made payable only to the Publisher, and when in sums of Five Dollars or less, should be made by Postal Note, Money Order or Registered Letter.

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SATURDAY, JUNE 3RD, 1893.

## EDITORIAL.

### FUROR—OPERANDI AND MODERN LISTERIANISM.

Probably in the whole realm of Medical Science, from its early origin to the present time, there never was a doctrine sprung on the profession, so to speak, which was so generally and eagerly accepted by the whole civilized world; which became so popular, and finally was regarded as a fixed dogma, that has been so short-lived as the *antiseptic* theory. To-day it must be admitted that orthodox antiseptic treatment is chiefly interesting only from an historical standpoint for it has, in recent times, been by many of our most respected authorities as fiercely condemned as it was in but the near past supported and recommended.

In Mr. Joseph Lister's address on Antiseptics, at the Queen's College Hospital, delivered on the 18th of January, 1893, it is only too apparent that he has found it necessary to turn his back on the offspring which, but a few short years ago, he gave to the world, and which was regarded as a boon of priceless value. But in this ad-

dress the spray is not mentioned and Bi-chloride of Mercury is declared an unreliable agent.

Chiene, in his address to the British Medical Association in 1891, declared that every sort of chemical solution was a foreign substance in a healthy wound. Gynecologists in a body cast aside antiseptics as useless and dangerous in the surgery of the peritoneum. The enormous stone or glass jars, the irrigating hose and the operator's wooden clogs to lift him out of the pools of irrigating fluids, these former indispensable appurtenances of the ideal operating room, have one and all been thrown out.

Manley, of New York, has called attention to the destructive irritation which he noticed when the corrosive solution was employed in cranial surgery, and reported a number of amputations in which, though primary union followed, useless stumps resulted, osteo-myelitis followed and consecutive amputation was required.

Antiseptics enormously increased the number of surgical operations for a time, so that for a while it seemed that the field of medicinal constitutional treatment would be greatly narrowed. We had a veritable *furor-operandi*. But it has swept over and now that the reaction has set in, we may ask "if these new theories have not led to too much mutilation, and if as good or even better results

might not have succeeded by tentative measures combined with an appropriate dietary, internal medication and more time."

Antiseptics have their place, but let us distinctly understand their powers and properties before we employ them, for without question their indiscriminate employment in the past has in many cases worked incalculable injury.

### THE NEW MEDICAL LAW IN PENNSYLVANIA.

#### AN ACT

To establish a Medical Council and three State Boards of Medical Examiners; to define the powers and duties of said Medical Council and said State Boards of Medical Examiners; to provide for the examination and licensing of practitioners of medicine and surgery; to further regulate the practice of medicine and surgery, and to make an appropriation to the Medical Council.

Whereas, the safety of the public is endangered by incompetent physicians and surgeons, and due regard for public health and the preservation of human life demands that none but competent and properly qualified physicians and surgeons shall be allowed to practice their profession.

SECTION 1. Be it enacted by the Senate and House of Representatives of the Commonwealth of Pennsylvania in General Assembly met and it is hereby enacted by the authority of the same. That there shall be established a Medical Council of Pennsylvania, consisting of the Lieutenant Governor, the Attorney General, the Secretary of Internal Affairs, the Superintendent of Public Instruction, and the President of the State Board of Health, and Vital Statistics and the Presidents of the three State Boards of Medical Examiners provided for in this act.

SECTION 2. The said council shall be known by the name and style of the Medical Council of Pennsylvania and may make and adopt all necessary rules and regulations and by-laws not inconsistent with the constitution and laws of this Commonwealth, or of the United States and shall have power to locate and maintain an office within this State for the transaction of business. Five members of the said council shall constitute a quorum for the transaction of business.

SECTION 3. The said council shall organize at Harrisburg within ten days from the date of the organization of three boards of medical examiners and shall elect from its own number a president and a secretary who shall also act as treasurer, both of whom shall hold their offices for one year or until their successors are chosen.

SECTION 4. The members of the said council shall receive no salary, except the secretary and treasurer, who shall receive a salary of not over five hundred dollars and who shall file with the president of the council a bond in the sum of one thousand dollars condition for the faithful performance of his duties. The necessary expenses of the said council shall be paid out of the appropriation made in section sixteen of this act and any balance remaining from the appropriation after the disbursements herein specified shall be paid into the Treasury of the Commonwealth.

SECTION 5. The said medical council shall hold two stated meetings in each year at Harrisburg and may hold special meetings at such times and places as it may deem proper. It shall supervise the examinations conducted by the three State Boards of Medical Examiners of all applicants for license to practice medicine and surgery in this Commonwealth and shall issue licenses to practice medicine and surgery to such applicants as have presented satisfactory and properly certified copies of licenses from State Boards of Medical Examiners or State Boards of Health of other States as provided for in section thirteen of this act, or as have successfully passed the examination of one of the three State Boards of Medical Examiners, but all such examinations shall be made by the State Boards of Medical Examiners established in section six of this act. And the said medical council shall have no power, duty, or function except such powers, duties, and functions as pertain to the supervision of the examinations of applicants for licenses to practice medicine and surgery and to the issuing of licenses to such applicants as have successfully passed the examination of one of the State Boards of Medical Examiners, or have presented satisfactory and properly certified copies of licenses from State Boards of Medical Examiners or State Boards of Health of other States as provided for in section thirteen of this act.

SECTION 6. It is further enacted that from and after the first day of March, Anno Domini one thousand eight hundred and ninety-four, there shall be and continue to be three separate boards of medical examiners

for the State of Pennsylvania, one representing the medical society of the State of Pennsylvania, one representing the homœopathic medical society of the State of Pennsylvania, one representing the eclectic medical society of the State of Pennsylvania.

Each board shall consist of seven members and each of said members shall serve a term of three years from the first day of March next after his appointment with the exception of those first appointed who shall serve as follows, namely: Two of each board for one year, two of each board for two years, and three of each board for three years, from the first day of March, Anno Domini one thousand eight hundred and ninety-four.

The Governor shall appoint the members of said boards of examiners respectively from the full lists of the members of the said medical societies, which shall on or before the first day of January, one thousand eight hundred and ninety-four, and annually thereafter, be transmitted to the Governor under the seal and signed by the secretary of the society so nominating. From these lists of nominees respectively the Governor shall during the month of January, Anni Domini one thousand eight hundred and ninety-four, appoint three separate boards of medical examiners, each board to be composed exclusively of members of the same medical society. In case of failure of any or all said medical societies to submit lists as aforesaid the Governor shall appoint members in good standing of the corresponding society or societies entitled to nominate without other restriction. Each one of the said appointed must be a registered physician, in good standing and shall have practiced medicine or surgery under the laws of this State for a period of not less than ten years prior to such appointment.

The Governor shall fill vacancies by death or otherwise for unexpired terms of said examiners from the respective lists submitted by the said medical societies and may remove any member of any said boards for continued neglect of the duties required by this act or on recommendation of the medical society of which said members may be in affiliation, for unprofessional or dishonorable conduct.

The Governor shall in his first appointments designate the number of years for which each appointee shall serve. The appointments of successors to those numbers whose term of office will expire on the first day of March, of each year, shall be made by the Governor during the month of January of such year upon the same conditions and requirements as hereinbefore specified, with reference to the appointment of three separate examining boards, each to be composed exclusively of members of the same medical school and society as hereinbefore provided.

**SectioN 7.** Said boards shall be known by the name and style of Boards of Medical Examiners of the State of Pennsylvania. Every person who shall be appointed to serve on either of said boards shall receive a certificate of appointment from the Secretary of the Commonwealth.

Each of said boards shall be authorized to take testimony concerning all matters within its jurisdiction

and the presiding officer, for the time being, of either of said boards, or of any of the committees thereof may issue subpoenas and administer oaths to witnesses. Each of said boards of examiners shall make and adopt all necessary rules, regulations and by-laws not inconsistent with the constitution and laws of this State, or of the United States, whereby to perform the duties and transact the business required under the provisions of this act, said rules, regulations and by-laws to be subject to the approval of the Medical Council of Pennsylvania established by this act.

**SectioN 8.** From the fees provided by this act the respective boards may pay, not to exceed said income, all proper expenses incurred by its provisions and if any surplus above said expenses shall remain at the end of any year it shall be apportioned among said examiners pro rata according to the number of candidates examined by each, *Provided*, That the Medical Council shall keep separate accounts of all fees received from physicians applying for licenses to practice medicine and surgery and shall not devote any such fees to the uses of the council or to the uses or remuneration of any other examining board than that of the society with which the physician who pays the fee wishes to be affiliated.

**SectioN 9.** The first meeting of each of the examining boards respectively shall be held on the first Tuesday of April, one thousand eight hundred and ninety-four, suitable notice in the usual form being given with the notice of their appointment by the Secretary of the Commonwealth to each of the members thereof, specifying the time and place of meeting.

At the first meeting of each of the boards respectively an organization shall be effected by the election from their own membership of a president and secretary. For the purpose of examining applicants for license each of said boards of medical examiners shall hold two or more stated or special meetings in each year, due notice of which shall be made public at such times and places as they may determine. At said stated or special meetings a majority of the members of the board shall constitute a quorum thereof but the examination may be conducted by a committee of one or more members of the board of examiners duly authorized by said boards.

**SectioN 10.** The several boards of medical examiners shall, not less than one week prior to each examination submit to the Medical Council of Pennsylvania questions for thorough examinations in anatomy, physiology, hygiene, chemistry, surgery, obstetrics, pathology, diagnosis, therapeutics, practice of medicine and *materia medica*. From the lists of questions so submitted the council shall select the questions for each examination and such questions for each examination shall be the same for all candidates except that in the departments of therapeutics, practice of medicine and *materia medica* the questions shall be in harmony with the teachings of the school selected by the candidate.

**SectioN 11.** Said examinations shall be conducted in writing in accordance with the rules and regulations prescribed by the Medical Council of Pennsylvania and shall embrace the subjects named in section ten of

this act. After each such examination the board having charge thereof, shall without unnecessary delay act upon the same. An official report of such action signed by the president, secretary and each acting member of said board of medical examiners stating the examination average of each candidate in each branch, the general average and the result of the examination, whether successful or unsuccessful, shall be transmitted to the Medical Council. Said report shall embrace all the examination papers, questions and answers thereto. All such examination papers shall be kept for reference and inspection for a period of not less than five years.

**SECTION 12.** On receiving from any of said boards of medical examiners such official report of the examination of any applicant for license the Medical Council shall issue forw<sup>r</sup>d to each applicant who shall have been returned as having successfully passed said examination and who shall have been adjudged by the Medical Council to be duly qualified for the practice of medicine, a license to practice medicine and surgery in the State of Pennsylvania. The Medical Council shall require the same standard of qualifications from all candidates except in the departments of therapeutics, practice of medicine and *materia medica*, in which the standard shall be determined by each of the boards respectively. Every license to practice medicine and surgery issued pursuant to this act shall be subscribed by the officers of the Medical Council and by each medical examiner who reported the licensee as having successfully passed said examinations. It shall also have affixed to it, by the person authorized to affix the same, the seal of this Commonwealth.

Before said license shall be issued it shall be recorded in a book to be kept in the office of the Medical Council and the number of the book and page therein containing said recorded copy shall be noted upon the face of said license. Said records shall be open to public inspection under proper restrictions as to their safe keeping and in all legal proceedings shall have the same weight as evidence that is given to the conveyance of land.

**SECTION 13.** From and after the first day of July, Anno Domini one thousand eight hundred and ninety-four, any person not theretofore authorized to practice medicine and surgery in this State and desiring to enter upon such practice may deliver to the Secretary of the Medical Council, upon the payment of a fee of twenty-five dollars, a written application for license, together with satisfactory proof that the applicant is more than twenty-one years of age, is of good moral character, has obtained a competent common school education and has received a diploma conferring the degree of medicine from some legally incorporated medical college of the United States, or a diploma or license conferring the full right to practice all the branches of medicine and surgery in some foreign country. Applicants who shall have received their degree in medicine after the first day of July, one thousand eight hundred and ninety-four, must have pursued the study of medicine at least three years including three regular courses of lectures in different years in some legally incorporated medical college or

colleges prior to the granting of said diploma or foreign license, and after the first day of July, eighteen hundred and ninety-five, such applicants must have pursued the study of medicine for at least four years, including three regular courses of lectures in different years in some legally incorporated medical college or colleges prior to the granting of said diploma or foreign license. Such proof shall be made, if required, upon affidavit. Upon the making of said payment and proof to the Medical Council, if satisfied with the same, shall issue to said applicant an order for examination before such one of the State Boards of Medical Examiners as the applicant for license may select. In case of failure at any such examination the candidate after the expiration of six months and within two years shall have the privilege of a second examination by the same board to which application was first made without the payment of an additional fee. And it is further provided, that applicants examined and licensed by State Boards of Medical Examiners or State Boards of Health or other States, on payment of a fee of fifteen dollars to the Medical Council and on filing in the office of the Medical Council a copy of said license certified by the affidavit of the president or secretary of such Board, showing also that the standard of requirements adopted by said State Board of Medical Examiners, or State Board of Health, is substantially the same as is provided by sections eleven, twelve and thirteen of this act, shall without further examination receive a license conferring on the holder thereof all the rights and privileges provided by sections fourteen and fifteen of this act.

**SECTION 14.** From and after the first day of March, Anno Domini, one thousand eight hundred and ninety-four, no person shall enter upon the practice of medicine or surgery in the State of Pennsylvania unless he or she has complied with the provisions of this act and shall have exhibited to Prothonotary of the court of common pleas of the county in which he or she desires to practice medicine or surgery a license duly granted to him or her as hereinbefore provided whereupon he or she shall be entitled upon the payment of one dollar to be duly registered in the office of the Prothonotary of the court of common pleas in the said county and any person violating any of the provisions of this act shall be guilty of a misdemeanor and upon conviction thereof in the court of quarter sessions of the county wherein the offense shall have been committed shall pay a fine of not more than five hundred dollars for each offence.

**SECTION 15.** Nothing in this act shall be construed to interfere with or punish commissioned medical officers serving in the army or navy of the United States or in the United States Marine Hospital service while so commissioned or medical examiners of relief departments of railroad companies while so employed or any one while actually serving as a member of the resident medical staff of any legally incorporated hospital, or any legally qualified and registered dentist exclusively engaged in the practice of dentistry, or shall it interfere with or prevent the dispensing and sales of medicines or medical appliances by apothecaries, pharmacists, or

interfere with the manufacture of artificial eyes, limbs or orthopedical instruments or trusses of any kind, for fitting such instruments on persons in need thereof, or any lawfully qualified physicians and surgeons residing in other States or countries meeting registered physicians of this State in consultation, or any physician or surgeon residing on the border of a neighboring State and duly authorized under the laws thereof to practice medicine and surgery therein whose practice extends into the limits of this State; Provided, that such practitioner shall not open an office or appoint a place to meet patients or receive calls within the limits of Pennsylvania or physicians duly registered in one county of this State called to attend cases in another county but not residing or opening an office therein. And nothing in this act shall be construed to prohibit the practice of medicine and surgery within this Commonwealth by any practitioner who shall have been duly registered before the first day of March, Anno

Domini one thousand eight hundred and ninety-four, according to the terms of the act entitled "An act to provide for the registration of all practitioners of medicine and surgery" approved the eighth day of June, Anno Domini one thousand eight hundred and eighty-one, and one such registry shall be sufficient warrant to practice medicine and surgery in any county in this Commonwealth.

SECTION 16. The sum of two thousand dollars is hereby appropriated out of any moneys in the State Treasury not otherwise appropriated, for the salary of the secretary and treasurer of said medical council and the necessary expenses of said council; one thousand dollars thereof for the year beginning January, one thousand eight hundred and ninety-four, and one thousand dollars thereof for the year beginning January, one thousand eight hundred and ninety-five.

SECTION 17. All acts or parts of acts of Assembly inconsistent herewith shall be and are hereby repealed.

## TRANSLATIONS.

### REPORT OF THE "MAISON D'ACCOUCHEMENTS BAUDELOQUE," UNDER THE MANAGEMENT OF PROF. A. PINARD AND REPORTED BY DR. G. LEPAGE.\*

This report containing an exhaustive study of all the possible phases of pregnancy, labor, delivery and subsequent complications presented in both a tabular and descriptive form, will be of interest to the obstetrician, those particular cases which occur less often in every day practice, may seem of interest given in the abstract.

One is an abdominal section done for extra-uterine pregnancy of seven months in a primipara, set. 28, married two years. Had always menstruated regularly until July 9th, when there was an omission, but in the latter part of August it returned; this ceased after a few days and was soon followed by abdominal pains extending to the lumbar region and small pelvis, necessitating the recumbent position. Morphia was administered but the symptoms continued for fifteen days after this slight improvement until October, when the same train of symptoms recurred and again diminished until November.

At this time she expelled portions of membrane with but slight bleeding or pain. A consultation resulted in making

a diagnosis of a retroverted pregnant uterus. Extra-uterine pregnancy was considered and dismissed.

Hot antiseptic injections and absolute rest were ordered. Toward the middle of December all painful symptoms disappeared.

The patient, though able to be up, tires very easily, her abdomen increasing in left lateral half, where a round tumor can be felt reaching to the level of the umbilicus. Not much general emaciation but great general weakness.

During February, motion was felt for the first time, which ceased after the third week.

The patient was admitted on the 20th of March; the tumor easily outlined, is immovable, about the size of a four months pregnant uterus, is tender to touch, and some fluctuation, but no motion can be detected; a mass below and to the right is found to be the uterus. The operation—April 1st, 1892—Median incision, the cyst is sutured to the abdominal wall, removal of dead fetus—290 gm. The placenta is left, the cavity cleansed with antiseptics and packed with iodoform gauze. April 30th the last of the

\*Translated for THE MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

placenta was removed. The patient was discharged May 29th.

One case of Ischio-pubiotomy after the method of Farabeuf, performed January 10th. 1893.

Patient at. 32; previous pregnancies:  
1st.—May, 1887; oblique flat pelvis;  
obliquity to the right; version; forceps;  
Basiotripsy.

2nd.—May, 1888; version; difficult extraction of the head; child resuscitated with difficulty; lived five months.

3rd.—May, 1890; midwife ruptured membranes. First doctor applied forceps five times. Second doctor applied once, also without effect. The author practiced version and delivered the body, but the head could not be extracted, and craniotomy remained unsuccessful; not until the combined force of three was used could the head be delivered.

4th.—September, 1891; induced premature labor, forceps, prolapse of the cord, child born dead.

5th.—September, 1892; on consultation with M. Faraboeuf it was deemed best to wait full term and then perform Ischio-pubiotomy.

Labor set in November 8th; afternoon; 9 A. M. November 9th the operation was performed. The Ischio-pubic articulation of the right side was divided by a chain saw—the child extracted with the aid of Farrier's forceps. The only sutures taken were those in the soft parts, the bone being readily placed in proper contact. The patient was treated same as those for symphysiotomy. December 19th, able to walk without difficulty; child weighed then nearly eleven pounds. There were thirteen symphysiotomies. Three children died after birth. One died the next day owing to an injury of the parietal portion of the cranium. The second died of cyanosis on the third day. The third died on day of birth, cause unknown.

The patients seem all to have recovered fully and are able to walk comfortably.

The following tables will give a more definite account of all the cases and their results, reported.

*Resume of the statistics of the clinic of Bandelocque from January 1st, 1890, to January 1st, 1893.*

Year	No. of Deliv'res	Total No. of Deaths	No. of deaths by Infection	MORTALITY	
				Total	By Fuerp. Infection
1890	1244	9	4	0.72	0.32
1891	1654	20	4	1.20	0.24
1892	1834	8	3	0.44	0.11
Total ..	4732	37	11	0.68	0.22

*Operations performed during the year 1803.*

		Primip.	Multip.
<b>76 Forceps—</b>			
Normal pelvis.....	34	7	6
Contracted pelvis .....	13	9	6
Face presentation .....	1	0	0
In cases of induced labor .....	2	0	0
Following Basiotripty.....	0	3	4
Cases which symphysiotomy followed the use of forceps.....	1	4	
Twin pregnancies .....	3	9	
<b>38 Extractions by the breech.</b>	<b>20</b>	<b>18</b>	
<b>11 Induced labor—</b>			
For contracted pelvis .....	4	4	
For other causes.....	3	0	
<b>9 Basiotripties—</b>			
Fetus dead before operation.....	0	4	
After application of forceps (died).....	0	3	
Performed on the after coming head .....	0	2	
<b>1 Simple craniotomy.....</b>	<b>0</b>	<b>1</b>	
<b>13 Symphysiotomies—</b>			
After induced labor.....	2	3	
After spontaneous labor.....	1	7	
<b>1 Ischio-pubiotomy.....</b>	<b>0</b>	<b>1</b>	
<b>1 Laparotomy for extra-uterine pregnancy.....</b>	<b>1</b>	<b>0</b>	
<b>10 Versions-Internal Manipulations—</b>			
For presentation of the shoulder.....	0	5	
Following induced labor.....	1	0	
After introduction of "Ballon Champertier".....	0	3	
Twin pregnancies.....	1	0	
<b>4 Embryotomies "cervicis".....</b>	<b>0</b>	<b>4</b>	
<b>1 Embryotomies "rachidiane," (after the method of Van Huevel and Tarnier.....)</b>	<b>0</b>	<b>1</b>	
<b>34 Artificial delivery—</b>			
For hemorrhage.....	1	11	
After operation (Forceps-Version).....	7	2	
After operation dead fetus.....	3	4	
After symphysiotomies .....	2	4	

MUSTAPARA		PRIMAPARA		SECONDARY	
No. of Cases	Recoveries	No. of Cases	Recoveries	No. of Cases	Recoveries
39° C	Above 39° C	39° C	Above 39° C	39° C	Above 39° C
38° C	From 38° C	38° C	From 38° C	38° C	From 38° C
37° C	No. above 37° C	37° C	No. above 37° C	37° C	No. above 37° C
36° C	Deaths	36° C	Deaths	36° C	Deaths
35° C	Recoveries	35° C	Recoveries	35° C	Recoveries
34° C	No. of Cases	34° C	No. of Cases	34° C	No. of Cases
33° C	Deaths	33° C	Deaths	33° C	Deaths
32° C	Recoveries	32° C	Recoveries	32° C	Recoveries
31° C	No. of Cases	31° C	No. of Cases	31° C	No. of Cases
30° C	Deaths	30° C	Deaths	30° C	Deaths
29° C	Recoveries	29° C	Recoveries	29° C	Recoveries
28° C	No. of Cases	28° C	No. of Cases	28° C	No. of Cases
27° C	Deaths	27° C	Deaths	27° C	Deaths
26° C	Recoveries	26° C	Recoveries	26° C	Recoveries
25° C	No. of Cases	25° C	No. of Cases	25° C	No. of Cases
24° C	Deaths	24° C	Deaths	24° C	Deaths
23° C	Recoveries	23° C	Recoveries	23° C	Recoveries
22° C	No. of Cases	22° C	No. of Cases	22° C	No. of Cases
21° C	Deaths	21° C	Deaths	21° C	Deaths
20° C	Recoveries	20° C	Recoveries	20° C	Recoveries
19° C	No. of Cases	19° C	No. of Cases	19° C	No. of Cases
18° C	Deaths	18° C	Deaths	18° C	Deaths
17° C	Recoveries	17° C	Recoveries	17° C	Recoveries
16° C	No. of Cases	16° C	No. of Cases	16° C	No. of Cases
15° C	Deaths	15° C	Deaths	15° C	Deaths
14° C	Recoveries	14° C	Recoveries	14° C	Recoveries
13° C	No. of Cases	13° C	No. of Cases	13° C	No. of Cases
12° C	Deaths	12° C	Deaths	12° C	Deaths
11° C	Recoveries	11° C	Recoveries	11° C	Recoveries
10° C	No. of Cases	10° C	No. of Cases	10° C	No. of Cases
9° C	Deaths	9° C	Deaths	9° C	Deaths
8° C	Recoveries	8° C	Recoveries	8° C	Recoveries
7° C	No. of Cases	7° C	No. of Cases	7° C	No. of Cases
6° C	Deaths	6° C	Deaths	6° C	Deaths
5° C	Recoveries	5° C	Recoveries	5° C	Recoveries
4° C	No. of Cases	4° C	No. of Cases	4° C	No. of Cases
3° C	Deaths	3° C	Deaths	3° C	Deaths
2° C	Recoveries	2° C	Recoveries	2° C	Recoveries
1° C	No. of Cases	1° C	No. of Cases	1° C	No. of Cases
0° C	Deaths	0° C	Deaths	0° C	Deaths

## MATERNAL HISTORIES.

No. of Births	Multipara	Death		Birth		After
		Recovery	Deaths	During	Before	
Primipara	Deaths	Recovery	Deaths	During	Before	Birth
		Recovery	Deaths	During	Before	Birth
Abortion	.....	.....	.....	.....	.....	.....
Spontaneous delivery—Normal Pelvis	69	67	2	12	775	2
Spontaneous delivery—Contracted Pelvis	46	45	1	1	61	21
Face presentation...	2	2	1	1	61	
Breech presentation...	19	19	1	1	18	3
Shoulder presentation	.....	.....	.....	.....	2	2
Forces applied to Normal Pelvis	32	31	2	1	7	3
Forces applied to Contracted Pelvis	12	10	1	1	5	1
Bastionary	.....	.....	.....	.....	5	2
Cranium	.....	.....	.....	.....	1	1
Induction of Labor—Contracted Pelvis	2	1	1	1	1	1
Induction of Labor—for other causes	2	1	1	1	10	3
Induction of Labor	3	3	1	1	7	2
Sympathotomy	.....	.....	.....	.....	5	2
Incision—Pubiotomy	.....	.....	.....	.....	4	2
Vaginum by external Manipulations	.....	.....	.....	.....	20	2
Extrauterine Pregnancy (7th month)	20	16	1	4	18	2
Twin Pregnancies	.....	.....	.....	.....	4	2
Death of Fetus in Utero	.....	.....	.....	.....	2	2
Mons trosties	.....	.....	.....	.....	2	2
Total	865	857	22	12	22	34
			909	875	26	15

### Apyretic Scarletna.†

Fiessinger, (*Gaz. Med. de Paris*, March 11, '93) says that the diagnosis between apyretic scarlatina and scarlatinoid erythemas is very difficult, since in the latter case the fever is always mild or absent, whatever may be the intensity of the eruption, according to M. Cadet, of Gassicourt. In apyretic scarlatina the fever may entirely be nil, although the eruption may be very marked. In analogous cases the examination of the temperature will not suffice to decide the differential diagnosis between this and the scarlatinoid erythemas. In a remarkable memoir M. Besmier has reported more especially in the scarlatiniform erythema the simultaneous appearance of the eruption and of the desquamation. This simultaneous occurrence exists equally in scarlatina, as has been designated by Cadet. Most important are the following familiar attributes of the erythema: The non-specific etiology, the variable and prolonged duration, the non-contagiousness, the characteristic

relapses (Besnier). It is true that these characteristics trace in general a clear line of demarcation between the two affections, and yet some objections present themselves. How are we to recognize a disease whose contagion is often, as that of scarlatina, caused by a third fever, a disease whose existence is, as scarlatina, endemic in the large centres, if occurring under specific etiological conditions. In the presence of a scarlatiniform erythema observed in a town, it will be impossible to decide between the one or the other. Fiessinger offers another objection, only however, in the forming of an hypothesis. We see that scarlatina in the apyretic form loses remarkably its classical features; nevertheless it remains contagious and its duration does not exceed a few days, thus differing from the erythema. Is this apyretic scarlatina, the last round to which the virulence of the pathogenic germ may descend? Do not there exist other concealed rounds still lower, including the so-called non-specific scarlatinoid rashes, so that the diagnosis with the scarlatinoid erythema may become illusory? Non-contagiousness and recurrence characterize in general the non-specific infections, but stripped of its classical specialty it is not impossible for scarlatina to appear under that form. The streptococcus encountered in scarlatina seems to be the same as that which causes the scarlatinoid eruption of the puerperium, of septicæmia, of diphtheria; it is also analogous to the streptococcus which occasions the primitive infectious erythema. Whenever this streptococcus has a very high degree of virulence will it not be capable of giving rise to a classical scarlatina, become specific from the degree of the virulence? We know that the acquisition of virulent properties creates in diseases moderately specific an approach to the true nature of specific diseases. Pneumonia becomes contagious; epidemic gripe assumes the marked stages of influenza; the exaggerated virulence gives the illusion of a true specific infection. May it not be the same with scarlatina? Say that the scarlatinous streptococcus is an agent of secondary infection; it does not signify that this streptococcus may give rise to a primary disease. Slightly virulent, it will give rise to a secondary scarlatiniform eruption; more virulent it will operate in its proper form and produce a true scarlatina.

<sup>†</sup>Translated for THE MEDICAL AND SURGICAL REVIEW, by W. A. N. Dorland, M. D.

Fiessinger draws the following conclusions:

1. There exists a form of scarlatina in which the fever may be entirely absent (below 38° by the rectum) or in which it may assume a number but slightly elevated, and that in an essentially transitory manner (by the rectum 38° to 38½°).

2. This form of scarlatina is observed in the same epidemic and alongside of the grave and pyretic forms; it is contagious and may give rise to the ordinary scarlatina complicated with Bright's disease, or with a pseudo-membranous angina.

3. There is no local sign to differentiate the apyretic from the ordinary scarlatina; the angina, the eruption, the desquamation are the same in their aspect and dura-

tion; the state of the tongue is, on the contrary, a little modified; we have not observed the raspberry tongue bristling with papillæ so peculiar to the ordinary scarlatina.

4. The pulse is not always accelerated in the apyretic scarlatina.

5. That which characterizes the apyretic scarlatina is the absence of general phenomena. Save the nights which are at times broken, the patients do not seem to suffer and are happy.

6. The diagnosis from certain scarlatinoid erythema is very difficult; it is a question whether the same germ, infectious in different degrees of virulence, does not produce both these erythema and the classical scarlatina.

## ABSTRACTS.

### THE REMOVAL OF THE GRAVID UTERUS BY ABDOMINAL SECTION.

Dr. More Madden, having in a former volume of the Transactions of the Royal Academy of Medicine in Ireland, reported a case in which he had been obliged to remove the gravid uterus, now in the present communication submitted the notes of a recent case of the same kind, together with some general observations on such operations.

In the last case referred to, in which he was compelled to perform a Porro-Müller's operation, the patient was a woman aged thirty-two, two months pregnant, and of well-marked carcinomatous cachexia, suffering from a fast-growing uterine tumour, which, from the intense suffering it occasioned, the rapidity of growth (it having so developed from the time it was first recognized, only three months previously, so as to fill the abdominal cavity, and cause such dyspnoea as to prevent her sleeping save in a sitting position) as well as from the extreme emaciation and characteristic cachexia, was diagnosed as probably malignant. The symptoms being most urgent, and the patient being apparently *in extremis*, it was decided as a forlorn hope to give her whatever chance the amputation of the uterus might afford. From the time of her being brought into the hospital

until she was placed on the operation table the patient was in a condition of extreme prostration from loss of rest, continual pain, and inability to take food, and was apparently kept alive by the free administration of stimulants. In that operation, which was performed on April 10th, 1893, he had the assistance of his colleagues, Drs. Leutaigue and Coppinger, and Dr. A. Smith, of St. Vincent's Hospital. The enormous tumour here shown, growing from the fundus was partially gangrenous, and owing to extensive adhesions there was considerable difficulty in its removal and in the ligation of the ligaments. The operation was, therefore, necessarily prolonged; and though she recovered from the immediate shock, and for a couple of days gave hope of recovery, she was then attacked by peritonitis, and sank rapidly.

The excision by abdominal section of the gravid uterus, which is generally known by the name of the operator, Professor Porro, of Pavia, by whom it was first successfully accomplished in 1879, though previously performed by Dr. Storer, of Boston, was originally designed as an obstetric operation in lieu of the Cæsarean section. It has been subsequently considerably modified and im-

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proved by Fruend, of Breslau, and Müller, of Berne, to whose operation, with several further modifications, More Madden has resorted to in three cases of pregnancy complicated by urgent symptoms arising from malignant, or supposed malignant, disease of the fundus or body of the uterus.

The mortality of Porro's operation under the most favorable circumstances, that is, in obstetrics where the condition of the uterus is presumably a normal one, has been 56 per cent.; hence the results in these three cases of removal of uterus for such disease as existed in all these cases—namely, two deaths, and one recovery, being a mortality rate of 66.6 per cent., considerably less than that of Freund's operation—are by no means exceptionally unfavourable when we consider the circumstances of these cases and the condition of the patients so operated on, as the last possible chance of relieving suffering and prolonging life in cases apparently otherwise beyond hope. At the same time More Madden thinks it only justifiable to perform such operations, as was the case in the three instances above referred to, as a *dernier resort*, in compliance, and with the entreaty of a patient fully aware of all the risk of the procedure and beyond other methods of relief.

Finally, in this connection, it may be added, that in obstetric practice, for which primarily designed as a substitute for Cæsarean section, there can be no ground now-a-days for recourse to either Porro's operation, or any of its subsequent modifications. Within the last few years, owing mainly to the improvements effected by Professor Sanger, of Leipsic, and also, and above all others, by Professor Murdoch Cameron, of Glasgow, the Cæsarean section (More Madden's first case of which was reported in "The Dublin Practice of Midwifery," published twenty-one years ago) has been robbed of its former terrors. No triumph of modern abdominal surgery has probably been equal to that which has taken place in the accomplishment of this operation by the method of Cameron, by whom the Cæsarean section has been performed in twenty cases with only two deaths, being a mortality hardly greater than that generally obtained in ordinary ovariotomy. With that method thus available, and with the exceptional experience of Cameron to guide us, it is,

Dr. More Madden thinks, therefore evident that we would no longer be justified in obstetric practice in resorting, whether by Müller-Porro or any other method, to an operation so terribly fatal as the removal of the gravid uterus has always proved and must always remain.

Dr. Lane would like to know could Dr. More Madden assign any cause for this rapid growth in what would appear to be a monster fibroma.

Dr. Tweedy asked if he had any reason to believe that the disease was confined to the uterus, and had not spread to the surrounding tissues. He did not see the necessity for washing out the abdominal cavity if nothing had got into it. If the blood has ceased, and if the clots have been taken away and asepsis assured, he did not see the use of a drainage-tube; it often ended in a faecal fistula.

The President said that Dr. More Madden appeared to think, from the constitutional symptoms present, that it was a case of malignancy. But then the woman was only thirty-three years of age, and there was no matting of the tissues, no disease of the cervix uteri. Another remarkable coincidence was the absence of ascites. The late Dr. Stokes always laid down that in such cases ascites was a sign of malignancy. The difficulty, to his mind, was how to account for the sloughing of the tumour. He thought that they must bow to the pathologists and agree with them that it was a large fibroid of the uterus. With regard to the choice of operation, he would be more inclined to the ideal operation—*i. e.*, removal of the uterus complete. He did not see the advantage of the drainage-tube.

Dr. More Madden, in reply to Dr. Lane as to the nature of the tumour, he (Dr. Madden) bowed entirely to the decision of the pathologist to the hospital, Dr. M'Feeey, but, at the same time, he ventured to think that before abdominal section any man might be justified, from all the symptoms—the extremely rapid growth, the constitutional cachexia and incessant local pain—in diagnosing it as malignant. As to washing out the peritoneal cavity, he must say that when the operator's hands, and possibly the hands of the assistant, have been introduced into the peritoneal cavity, he very much preferred washing out the cavity, because no amount of wasing of hands can possibly

prevent the risk of septic infection. He was not aware of any means of sterilizing the atmosphere<sup>6</sup> in the operating room, and therefore he thought washing out a wise precaution, and he would always continue to do it. He did not like the drainage-tube much, but in a large opera-

tion such as this one, and where there was the slightest danger of septic contamination, he thought they could not take too many precautions. They could also, if that should subsequently become necessary, wash out the peritoneal cavity through the tube.

### SOME OTOLOGICAL DON'TS.

That the ear is more sinned against by acts of commission than of omission in the treatment of its diseases, says Dr. Chas. M. Shields, is a statement that will be agreed to by most specialists, and may serve as an excuse for the negative title of these remarks.

*Firstly. Don't syringe the ear except for a purpose.* That is, do not use the syringe on general principles with every patient that complains of his ear, but restrict the use of the instrument to its legitimate purpose of removing extraneous matter such as foreign bodies, wax, pus, etc.

It is too often the case that patients are directed to syringe their ears because it is easier to give such advice than to make a diagnosis. Warm water is not a panacea for all diseases of the ear, and it is as important to make a diagnosis here before applying remedies as it is in the treatment of other organs.

Should the family physician not always have an ear speculum and mirror with him, a truncated cone of stiff paper will answer for one and an ordinary hand-glass for the other. With their aid, and, after the auditory canal has been cleansed by the proper use of warm water, it can be determined whether the syringing can appropriately be continued for the removal of products of suppuration, or as the medium of conveying antiseptic agents to the parts, or for the poultice-like effect of the hot water; or whether its continuance would not rather do the harm that not infrequently results from its softening and soddening effect upon the drum and other tissues. Eczema, for which the auditory canal is such a favorite site, is confessedly made worse by the application of moisture, and yet I suppose that out of every twenty such cases that I see, syringing has been suggested in nineteen of them. In long-continued inflammations

of the walls of the auditory canal and the drum, unless there are discharges to be removed, the constant use of water soddening the tissues and makes them an easier prey to inflammatory processes.

*Secondly. Don't use instruments to remove foreign bodies from the ear until the syringe has failed.* The ingenuity that has been displayed in inventing instruments for the removal of foreign bodies from the ear is worthy of a better cause. A well-directed stream of warm water will accomplish the desired result in the vast majority of cases.

Not with the so-called ear-syringe, however, that is commonly sold in the drug stores, that has its end rounded into a bulbous extremity, which effectually prevents your directing the stream to any particular place; but with an instrument that will hold at least four ounces and that has a long tapering nozzle which will permit you to throw the water along the wall of the auditory canal which permits its easiest flow behind the foreign body.

Some of the suggested appliances have been of the gimlet order, and, while being screwed into the foreign body, pushes it through the drum. A form of lever in the hands of an experienced person is often an effective and safe instrument, but if carelessly used may do great damage to the walls of the canal. While slender forceps are useful when the object to be removed is not large, they are useless when most wanted because of the lack of space for their introduction between the foreign body and walls of the canal. Where the syringe fails, perhaps the most satisfactory and safe instrument is a loop of silver wire gently insinuated around the foreign body.

*Thirdly. Don't consider and speak of all pain in the ear as a neuralgic earache.* Are not physicians largely responsible for

the laity considering inflammatory pain in the ear as a neuralgic earache? Ninety-nine per cent of our patients so describe it. As we all know, the fact is that nearly all pain in the ear means *inflammation* there—acute, catarrhal, or purulent inflammation of the middle ear that may rupture the drum, impair hearing, or extending into the mastoid, result fatally. Or else inflammatory processes in the auditory canal that, while not serious in their results, are usually attended by several days of acute discomfort.

Pain in the ear is rarely neuralgic in character, and is no more properly described as *ear-ache* than would be gastritis as *gastral-gia* or peritonitis as *belly-ache*.

This misnomer often lulls the patient into a false sense of security that is only dissipated when he discovers that he has a resulting ruptured drum, and that his hearing is permanently impaired.

Fourthly. *Don't prescribe sweet oil for pain in the ear.* In the first place, it does no good. The sense of comfort which may follow the use of any warm liquid poured in the ear may be obtained just as well by a harmless one.

Sweet oil or any vegetable or animal oil may undergo decomposition and make favorable soil for the growth of aspergillus or other vegetable fungi which may be most destructive to the organ. Then it gums up the canal and interferes with examination subsequently.

Fifthly. *Don't lose sight of the fact that the auditory canal and external surface of tympanum is not an absorbing surface.* If you do, you will often be disappointed in the effect of agents prescribed to be dropped in the ear. The lining of

these parts being a continuation of the skin does not possess the absorbing properties of mucous membranes, and agents are sparingly, if at all, taken up. If there be an exception it is with the combination of atropia and cocaine—one grain of the former and six of the latter in two drachms of water. This should not be used, of course, where a perforation of the drum is known to exist or where an otorrhœa would suggest a perforation, as an excessive quantity might find its way to the throat through the eustachian tube. Six or eight drops of this solution instilled warm into the ear often relieves pain to a marked degree. As a rule, however, absorption of remedies in the auditory canal is so limited as to make their use very unsatisfactory.

Sixthly. *Don't tell your patient that it is dangerous to stop an otorrhœa.* This injunction would seem an unnecessary one were it not for the fact that scarcely a day passes that some patient does not give as an excuse for the neglect of an otorrhœa of years' duration that his doctor told him it would be dangerous to stop it. As well consider it dangerous to stop a gonorrhœal flow or a leucorrhœal discharge!

Purulent discharge from the middle ear means the continuance of inflammatory action there with the resulting damage to the parts and the added danger of extension into the mastoid process.

To neglect to treat the cause of an otorrhœa is not only to sacrifice the sense of hearing without an effort, but in endangering life, as is evidenced by the refusal of life insurance companies to accept as risks individuals having a chronic discharge from the ear.—*Practice.*

#### THE TREATMENT OF GANGRENOUS INTESTINE.

In a certain proportion of cases of strangled hernia the bowel is found in a gangrenous condition, and the treatment of such cases in the past has practically been limited to relieving the constriction and to the creation of an artificial anus. The mortality under these circumstances is very considerable, in fact, the discovery of gangrenous intestine has hitherto been looked upon as an indication of the hopeless nature of the case. Judging from a

paper read by Dr. Kendal Franks before the Medical and Chirurgical Society, these cases are not as hopeless as statistics would lead one to infer. He urges with some show of reason, basing his conclusions on a tolerably extensive array of statistics, that resection of the gangrenous gut with immediate suture affords the patient a much better chance of recovery. Nor was this conclusion seriously questioned by the experienced surgeons who

had assembled to hear what the author had to say on behalf of a procedure that certainly strikes one as severe, considering the usually very depressed condition of such patients. The discussion turned mainly on the question as to whether the operation should be completed on the site of the original wound made for the relief of the femoral or inguinal hernia, or whether, after the preliminary palliative measures, it should be performed through a median abdominal incision made for the express purpose. Opinion on the whole was in favour of the resort to abdominal incision, and this is probably the view that will commend itself to most unprejudiced surgeons. It is evident that the thoroughness of the examination of the gut and the freedom of manipulation could never be the same through such a small aperture as that afforded by the inguinal or the crural canal, apertures, moreover, which cannot be safely enlarged. By this procedure the mortality has been reduced from something like 95 to about 56 per cent., a brilliant enough achievement considering the very unfavourable circumstances under which it is necessarily undertaken. One point that came out

very clearly in the discussion was the impunity with which relatively considerable lengths of gut can be removed. One case was mentioned in which over a yard had been removed, and this without interfering with the recovery of the patient. It is indeed all important to remove every inch of damaged tissue, otherwise no suture, however perfect, can be relied upon to hold. A very large proportion of the failures after enterectomy are attributable to non-compliance with this salutary rule, and it cannot be too strongly impressed on surgeons that the kind of suture is of far less importance than the fact of its being applied to healthy tissue. There must, of course, always be cases which come under treatment at such a late period that nothing can be done. These "too late" cases are the operator's horror, for they weigh down on the statistics with an unduly large proportion of fatalities, although death has really nothing to do with the operation *per se*. Dr. Franks has called attention to a means of rescuing a certain proportion of patients otherwise condemned to inevitable death, and he has succeeded in divesting gangrenous intestine of half its terror.—*Med. Press and Circul.*

#### NEURALGIA.

Dujardin-Beaumetz writes: A most interesting study, even from a practical or therapeutical standpoint, is that of the true seat of neuralgic pain. The entire subject can be reduced to a single question. Is the pain of the different forms of neuralgia really originated at the very spots at which the patients complain of it, or is it simply felt at those spots as though it arose there, in the same way, for instance, as patients who have undergone amputation of a limb, still complain of pain in the stump although the limb, which was the seat and sole cause of their suffering, has been removed?

The former hypothesis seems probable *a priori*, and has given rise to the so-called peripheral theory of neuralgia; but a number of neuropathologists, and among them some very eminent men, defend what is known as the central theory of such suffering. Although there can be no doubt that the latter theory is

not applicable to all cases, still it accounts for the greater number of them, and is based on arguments that are well fitted to carry conviction, and of which the principal ones are the following:

When the nerve has been completely severed, as is sometimes done in cases of neuralgia that defy all treatment, it is not uncommon to find the pain going on unchanged after the operation; it could not, therefore, have had a peripheral origin.

Just as no one disputes nowadays the existence of nutritive disorders in hysteria, in the same way no one can deny that in certain forms of neuralgia, without neuritis, the same kind of disorders may arise. Now, is not the most rational way of explaining these disorders that of granting the central theory of neuralgia? Under these circumstances it is easy to see that the morbid irritation extends from the original nucleus of the diseased nerve to the original nuclei of the neigh-

boring nerves, which will manifest their implication by creating nutritive disorders *loco dolenti*.

In the third place, a number of diatheses, and in certain altered conditions of the blood, give rise to neuralgic pains, unless we admit that the spine is affected primarily, how can we understand why these diatheses and modifications of the blood should affect one nerve more than another, and, in some cases, only a few centimetres, or even millimetres, of a given nerve?

Fourthly, it is known that neuralgic pains are connected very closely in different ways with hereditary neuroses. Now, the latter are undoubtedly localized in the nervous centres; how, therefore, could their effects be other than central?

The theory of the central seat of neuralgic pains explains most satisfactorily, (and is the only theory that does so) the way in which such pains jump from one spot to another, alternate from one side to the other, and pass rapidly from this

nerve to the next. We know how near to each other in the spinal cord are the original threads of the different nerves, and can consequently understand with readiness how the painful irritation of one nerve can extend with the greatest ease to its neighbor in the spinal cord.

After all, the daily practice of medicine supplies the central theory of neuralgic pains with a decisive argument. It is a matter of common occurrence that cases of neuralgia of the trigeminal, sciatic, or superficial nerves, that have stubbornly resisted the action of various local anaesthetics and different forms of counter-irritation, disappears as if by magic after only a few days' use of bromidia. This extraordinary result is readily explained by the well-known physiological effects of the active elements of bromidia. Purified brom. potass. and chloral, cannabis indica, and hyoscyamus; for it must be remembered that they act on the cerebro-spinal centres.—*Bulletin General de Therapeutique*, Paris.

#### PROFESSOR LIEBREICH ON MINERAL WATERS.

The *British Medical Journal* reports that in a paper on Artificial and Natural Mineral Waters, read by Professor Oscar Liebreich at the Balneological Congress recently held in Berlin, he began by asking:—Is chemistry sufficiently advanced yet to produce artificial mineral water equal in all respects to the natural water? The answer is negative. The artificial production of mineral waters is a much more difficult matter even than the production of alizarine, indigo, &c., and the analyses even of the most renowned analysts, fall short of the full contents of the water. In the natural mineral water, on evaporation, there is always a residuum which is not contained in the analyses of the artificial mineral waters. The carbonic acid gas which furnishes the effervescence of natural mineral water exists also in the form of "carbonic acid hydrate." This has been inferred from the existence of another combination derivative from it, namely, carbonic acid ethyl, which is probably contained in champagne and in other alcoholic effervescent drinks, and is known for its agreeable

taste. It may be supposed that the action of an hydric carbonic acid gas is different from that of carbonic acid hydrate. "Even the best manufactured mineral waters," Professor Liebreich points out, "differ from the natural ones in taste and value; this difference it is not easy to explain." He concludes by observing that, "As to the so-called 'indifferent springs, it is a mistake to speak of them as of minor value.' It must be remembered that they, too, contain mineral ingredients, if only in minimum quantities, which counteract the effects of perfectly pure distilled water. Even hydrotherapy is a mineral water treatment, for if the water used were without traces of mineral substances it would be poisonous. This has been sufficiently proved elsewhere."

#### Hard to Please.

*Buyer*.—"This doesn't seem to be a very good fit."

*Dealer*.—"Vot do you egspect for two tollars and a helluf? An attack of ebilepsy?"—*Brooklyn Eagle*.

## SELECTED FORMULÆ.

## Abscesses.

R Calci sulphidi..... gr. i  
Sacchari lactis..... gr. x  
Misce et fiant chartulae..... No. x  
Sig.—Take one powder every two hours.

## Alcoholism (Chronic).

R Tincturae capsici.....  
Tincturae sanguinariae.....  $\frac{1}{2}$  fl.  
Tincturae valerianae ammo.....  
Tincturae gentianae comp.....  $\frac{1}{2}$  fl.  
M. Sig.—Take a dessertspoonful in a teacup of hot tea three or four times a day.

—Gerhard.

## Pruritus of the Vulva.

Meisel makes use of the following lotion:

R Potassium bromide,  
Lupulin.....  $\frac{1}{2}$  fl. ss  
Calomel..... ss ss  
Olive-oil..... ss

—Deutsch Med. Wochenschr.

## Fissures of the Tongue.

R Acidi carbonici..... ss  
Tr. iodi..... ss  
Glycerinae.....  $\frac{1}{2}$  f ss  
M. Sig.—Use locally.

—Med. Bull.

## Fissured Breast.

Dr. Behren makes use of:

R Ichthiol..... ss  
Lenolin.....  
Glycerini.....  $\frac{1}{2}$  ss  
Olive-oil or oil of sweet almonds.... ss

—Therap. Gazette

## Chronic Eczema.

Dr. Jaquet orders:

R Yellow oxide of mercury..... gr. vii-xv  
Oil of cade..... mxxv-ss  
Pure vaselin..... ss

—Prescription.

## Vaginismus.

The following is recommended by De Sintey as affording relief in obstinate cases of vaginismus:

R Thymol..... gr. iii  
Ext. belladonnae..... gr. xii  
Potassii bromidi..... ss  
Ol. theobromae..... ss  
M. et ft. suppositoria no. iv.

Sig.—One suppository, as needed.

—N. Y. Med. Record.

## Soothing-syrup without Opium.

R Oli anise..... mxxv  
Alcohol ..... ss  
Fl. ext. valerian..... ss  
Oli peppermint..... mxxv  
Tinct. camphor..... ss  
Fl. ext. licorice..... ss  
M. Sig.—Shake the bottle. Dose,  $\frac{1}{2}$  or  $\frac{1}{4}$  teaspoonful in water; repeat as needed.

—Med. Age.

## Hiccough.

Dr. J. W. Allen, of London, recommends:

R Olei succini ver..... ss  
Liquor potassae..... ss  
Tinct. camphor comp..... ss  
Mist. acaciae..... ad ss  
Aq. menth. pip..... ss

M. Sig.—One-sixth every two hours.  
Two doses usually succeed. — Quarterly Therapeutic Review.

## For Exophthalmic Goitre.

R Ferri et quininæ citratis..... gr. xxx  
Tincturae digitalis..... mxxx  
Tincturae chiratae..... ss  
Aquaee..... ad ss  
M. Sig.—A sixth part three times daily after meals.

—Med. Record.

Food for infants, (in use at the Children's Home, Philadelphia Hospital).

Russian isinglass 2 inches square allowed to dissolve over night in  $\frac{1}{2}$  tea cup of cold water, to this add one pint of milk and boil, then add one drachm of arrowroot and one ounce of cream.

## Epistaxis, (in Anemic Cases).

R Strychnine sulphatii..... gr.  $\frac{1}{2}$   
Tincturae ferri chloridi..... ss  
Vini ergotatae..... ss  
Elixir simplicis..... ss  
Aquaee destillatae..... ss ad ss  
M. Sig.—Take a tablespoonful 3 times a day.

—Lombe Athill.

## Epistaxis, (in Plethoric Cases).

R Tincturae aconiti radicis..... mvij  
Liquoris ammonii acetatis..... ss  
M. Sig.—Take a teaspoonful every half hour.

—Thomas.

## Epilepsy, (to Prevent Nocturnal Fits.)

R Choralis hydratis..... 3 ss  
Syrupi simplicis..... ss  
Aquaee destillatae.....  $\frac{1}{2}$  ss  
Misce et fiat haustus.  
Sig.—Take at bedtime.

—Da Costa.

## Epilepsy.

R Amonii bromidi.....  $\frac{1}{2}$  ss  
Potass iodidi..... ss  
Potass bromidi..... ss  
Sodii bicarbonatis..... ss  
Tincturae calumbaee..... ss  
Aquaee destillatae..... ss  
M. Sig.—Take a dessertspoonful after each meal, and tablespoonful at bed time.

—Brown-Segard.

## Dysmenorrhœa.

To restore the menstrual flow after suddenly checked:

R Tincturae opii deodorate..... ss  
Extracti cimicifugae..... ss ss  
Syrupi simplicis..... ss  
M. Sig.—Take a teaspoonful every three or four hours.

—Ringer.

June 3, 1893.

## Selected Formulae.

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## Enteritis.

R	Liquoris potassi arsenitii.....	3ss
	Tincturae opii deodoratae.....	3i
	Tincturae calumba.....	3iv
M.	Sig.—Take a dessertspoonful every two or three hours.	

—Martin.

## Diabetes.

When gluten bread is used the following formula is useful to make up the deficiency in phosphates:

R	Calcis phosphat.....	gr. iij
	Magnes. phosphat.....	gr. ss
	Potassii phosphat.....	gr. iv
	Ferri phosphat.....	gr. ss
	Acid phosphoric (60 per cent).....	m vj <i>ss</i>
	Aqua.....	qs. ad. 3i

M. Sig.—One dose, to be taken daily well diluted.  
—William Pepper.

## Treatment of Pain in Eye-disease.

When the pain is of corneal origin, Dr. E. Jackson employs one of the two following solutions:

R	Neutral sulph. atropine.....	
	Muriate of cocaine.....	ââ gr. j
	Distilled water.....	3ij

M. Sig.—Instill one drop of this solution into the eye every four to six hours.

R	Sulphate of eserine.....	gr. 1/6
	Muriate of cocaine.....	gr. iss
	Distilled water.....	3iv

M. Sig.—Instill a drop into the eye every four to six hours.

—Western Med. Reporter.

## Ingrowing Toe-nail.

R	Muriatic acid,.....	
	Nitric acid.....	ââ 3j
	Chloride zinc.....	3j

M. Sig.—Apply 1 drop to the affected part once a day. This gives instant relief to the pain caused by ingrowing toe-nail.

—The Prescription.

## Bright's Disease.

In threatened uremia Professor Da Costa recommends:

R	Caffeinae.....	gr. ij
	Sodii benzoatis.....	gr. x
	Syr. aurantii.....	q. s.
	Aq. destil.,.....	ad 15ij

M. Sig.—Take 1 ounce every four hours, largely diluted in water.

Coll. and Clin. Record

## Dressing for Abdominal Operation Wounds.

Dr. Howard A. Kelley, of Baltimore, uses:

R	Squibb's ether, or washed ether, and alcohol, absolute.....	eq. parts
	Bichlor. of mer. (Merck's recryst.),	
	enough to make the solution.....	1-16,000.

Anthony's snowy cotton..... enough to make a syrupy consistency, added in small pieces, stirring.

As soon as this is poured over the wound evaporation begins to take place at once, and the celluloidin hardens, gumming the gauze ast to the skin. To avoid delay in waiting for this to grow quite hard, and to prevent adhesion to the cotton applied above it, the

whole surface is freely dusted over with a finely-powdered mixture of iodoform and boric acid:—

R	Pulvis iodoformi.....	3j
	Acidi borici.....	3vj
	M. Exactissime	

Sig.—Dust freely on wound.

This powder is of itself an invaluable protective. He uses it constantly in obstetric cases, separating the labia and throwing it into the vagina, where it acts as a guard to the vaginal outlet against septic invasion from without.

—Am. Jour. Obst.

## Battery Fluid.

R	Potass. bichromat.....	3ij
	Aqua.....	1/2 gal.
	Acid sulphurici.....	3vj ss

Allow to stand six hours before using.

—Ex.

## Battery Fluid.

Dissolve 1½ ounces of Bichromate of Potash in twenty-four ounces of hot water and add ¾ ounces of Saltpetre—let this cool, then add 3 ounces of Commercial Sulphuric Acid, cool again and add a solution of ¼ ounce of Bisulphite of Mercury in 3 ounces of cold water. This gives Oil of fluid. Do not use until cold.

—W. H. Bricker-

## Dysentery, (in Chronic Dysentery).

R	Cupri sulphatis.....	gr. i
	Pulveris opii.....	gr. iij
	Quininæ sulphatis.....	gr. xxiv
	Misce et fiat pilulae.....	No. xij

Sig.—Take one pill 3 times a day.

—Joy.

## Dysentery, (in Acute Dysentery).

R	Cupri sulphatis.....	gr. ss
	Magnesii sulphatis.....	si
	Acidi sulphurici diluti.....	si
	Aquaæ destillatae.....	3iv

M. Sig.—Take a tablespoonful every 4 hours.

—Bartholow.

## Mercurial Stomatitis.

Dr. Feibes regards dentifrice powders and gargles as the best means of preventing mercurial stomatitis during a "course" of mercury. He uses the following powder as a dentifrice:

R	Cretæ preparat.....	grms. xxxij
	Potass chlorat.	
	Corticis cinchonæ rubrae. ââ grms. xv	
	Ratanhiae.....	grms. x
	Sapon. medical.	grms. xxij
	Essent. menth. piperit.....	grms. iiij

M.

As a gargle he employs:

R	Alumin. acetat.....	grms. x
	Aq. destillat,	
	Aq. flor. aurantior.....	ââ grms. cc

M.

If the gums become sensitive they may be sponged three times a day with:

R	Tinct. myrrhae,	
	Sinct. nuc. gall,	
	Tinct. ratanhiae.....	ââ grms. v

M.

—Med. Review.

## CURRENT LITERATURE REVIEWED.

## THE OPHTHALMIC REVIEW

For March has an original paper by John B. Story, on

## Cases of Glaucoma in Young People.

As primary glaucoma before middle age is of such rare occurrence, the five cases reported are of more than ordinary interest. The patients ranged from 13 to 35 years of age. "The first case is not one of primary glaucoma in the strictest sense of the term." Case I—"Acute glaucoma after subconjunctival injection of cocaine in a girl of 13." The patient was suffering from convergent strabismus and hypermetropia. In May, 1890, the tendon of the right internal rectus was divided under cocaine anaesthesia, the pupils at the time being widely dilated by atropine used some hours previously. About two hours after the operation she was attacked with acute glaucoma, intense pains and photophobia. Frequent instillations of eserine in about two hours reduced the tension to normal, the pupil was contracted to about half its former size and all pain was gone.

About a month later the left internal rectus was tenotomised, and although no atropine was used, and two minims of eserine were instilled at the time of the operation an exactly similar attack of acute glaucoma occurred in this eye about two hours after the operation. It took 4 m. of eserine every quarter of an hour to cure this attack of glaucoma which lasted for one hour. Case II. "Chronic inflammatory (?) glaucoma in a woman of 18." When first seen in March, 1890, this patient had been married one month, and stated that her sight had failed subsequently, with pains in the eyes, although it was afterwards elicited that three months previously she had noticed "blue rime to lamps." It was a typical case of glaucoma. Right eye—hand reflex in temporal field. Left eye—fingers at 0.5 m. in temporal field. A large sclerototomy was performed upwards in each eye, and two days afterwards T. which had been T. +2 in both eyes was reduced to T.n. When seen two years later the patient's vision in right eye was about the same as before the operation, but with the left she could count fingers at 2 m. and decipher Wecker's type No. 8. Case III. "Acute glaucoma of one eye in a woman of 35." Case IV. "Chronic inflammatory glaucoma in a man of 30." This patient lost the sight of his left eye every evening. At the time of being seen Nov. 16, '89, left eye V=5/10? whilst right eye V=5/5. His mother had noticed his left pupil getting big at the time when his sight grew dim. He had very shallow anterior chambers, and quite microphthalmic looking eyes; corneal diameter =11 m. m. R and L Tn R and L, as also fundus. Venous pulsation in left disc. Ordered boric acid and nitrate of pilocarpine. On December 3rd, he returned to say that he was then suffering

an attack—the second since using the pilocarpine, which had evidently done good, as the attacks were previously of daily occurrence. Left pupil was wider than right T+2. The left fundus exhibited both venous and arterial spontaneous pulsation. The larger arteries pulsated both on the disc and for some distance also in the surrounding retina. On the next day, after using eserine the previous night, the pupil was contracted, the tension was normal and the symptoms of colored haloes round lights and dimness of sight had quite disappeared. The pupil was too small for thorough ophthalmoscopic examination, but so far as could be seen no pulsation was present in the retinal vessels. On Feb. 1, 1893, the patient presented himself with an attack of a novel description. He had had no attack Dec. 3, 1892 and had used pilocarpine drops daily till January 30, when he forgot to put them in. That night he got an attack, in his opinion, exactly like the one of Dec. 3, but it continued unabated except in one respect, that the pain which marked its commencement had subsided. The eye (left) had a zonular vascularity; dilated pupil; V=5/30. Disc slightly hazy, but cornea clear with no keratitis punctata; very shallow anterior chamber, no visible pulsation, and to Dr. Story's astonishment, T-1. Next day V rose to 5/15 but T remained —1. On March 6th, the patient had another distinctly glaucomatous attack with +T 1, venous and arterial pulsation, dilated pupil and keratitis punctata. He was advised to submit to iridectomy. Case V. "Chronic inflammatory glaucoma in a man aged 34, associated with keratitis punctata." When first seen on Dec. 3, this patient complained of a fog before his right eye and a rainbow halo around light V=5/15 T+1 whilst left eye had V=5.7.5. T.n. In this case eserine was used for several weeks with evident improvement, but soon after the myotic had been discontinued he had two relapses and on January 14th, an iridectomy was performed upon the right eye. Six days after the operation, the eye was practically well, when unfortunately, during his sleep, the patient let his hand fall upon it, and he awoke with intense pain, to find the eye completely blind. The wound had been burst open and the anterior chamber was filled with blood clot T+1. In a fortnight all trace of blood had disappeared. T.n. media clear; V=5/50; after another week V+2 D cyl=5/10 T.n.

In his comments upon these cases the author remarks:—"Priestly Smith regards a narrowing of the circumtentorial space as the underlying cause of glaucoma, and the determining conditions may be either abnormally large lens, an abnormally small ciliary region, or an abnormal enlargement of the ciliary processes. It is unlikely that an abnormally large lens was present in any of the causes here recorded. The age of the patients renders such a supposition im-

probable, and the only case which shows any evidence of an abnormally small ciliary region is case IV, in which the diameter of the cornea was only 11 m. m. The diameter in all the others was above the average."

This paper is followed by a report of three cases of "Congenital Ptosis with associated movements of the affected lid," by Walter N. Sinclair. The writer says: "Some fifteen cases only of this curious condition are on record, and it will be noted that all these three cases agree in the following particulars: (1) There is congenital Ptosis. (2) The left upper lid is affected. (3) While the eyelid cannot be voluntarily raised, it moves upwards freely when certain of the masticatory muscles are thrown into action." This is followed by a very able abstract of an important article covering more than 200 pages of Von Grafe's Archiv., by O. Schirmer (Halle) entitled "A clinical and Pathological study of the Pathogenesis of Sympathetic Eye Inflammations." After an exhaustive discussion of the exciting causes of sympathetic eye inflammation the author seems decidedly to favor the theory that the inflammation is due to "bacterial migration" and not to "nerve irritation." A direct migration from the one eye to the other appears to be the probable course. "Whether the path lies along the optic nerves or through some other channel or through both, remains uncertain." Our author considers that an eye which is blind, and which is in the condition to excite sympathetic inflammation should be exercised without waiting for any sign of sympathetic irritation; "or if sympathetic inflammation has already broken out, the exciting eye, if blind, should be removed." "If the sympathetic inflammation breaks out while the exciting eye still retains some vision, the exciting eye must not be excised." The sympathetic inflammation itself appears to be best influenced by sweating, mercurial inunction, warm compresses, darkness, atropine, and absolute rest of the eye." This number of the *Review* concludes with a reference to Uhthoff's paper "On the Anatomical changes underlying the Ocular disturbances of Cerebral Syphilis."

**THE CANADIAN PRACTITIONER**  
for May contains a paper by E. Herbert Adams, M. D., D.D.S., on

#### Alveolar Abscess.

In regard to the diagnosis, it is easy in most cases but in some forms it seems to be a matter of difficulty for the general practitioner. The author reports several cases which were mistaken for diphtheria, carbuncles, strumous enlargement, etc.

A simple means of testing whether a tooth is abscessed is by rapping the tooth with an instrument. If it should prove tender on pressure, the apical pericemental membrane is inflamed, and the root of the tooth probably abscessed.

Abscesses most frequently occur on teeth with dead pulps. In such teeth the natural translucence of the tooth is gone, the dentinal

tubuli being filled up with dead matter, due to the disintegration of the pulp. The dark color and opacity is often very marked, but is occasionally so slight as to escape notice. If, however, the patient is placed in the sunlight and the rays of light reflected on the teeth by means of a mirror, a slight opacity will be noticed.

The patient's notice is often directed to a painful tooth as a possible cause of the trouble, but it must be remembered that neither a decayed tooth nor pain need necessarily be present. The pulp may have died from some other cause, and the diagnosis can be made by the opacity of a tooth and its tenderness on pressure.

The treatment is comparatively simple in most cases, and consists in the evacuation of the contents of the pus cavity, and in injections of antiseptics until it is rendered thoroughly aseptic.

In the more simple cases this is readily accomplished by a dentist drilling through the root canal and thus allowing an exit for the pus, and an opening through which antiseptics can be injected. It is rare, indeed, that a skilled dentist cannot successfully treat even the worst cases by this means. Of course, if the offending tooth is for any reason considered of no value, the simplest method of cure is its removal, when the abscess will, as a rule, heal without any medication.

In some cases a simple way is to drill through the alveolus, just above the root of the tooth, and thus give an exit for the pus, and an opening for antiseptic medication. If it is desirable to keep this sinus open, a simple method is to place a pedgelet of cotton, soaked in a strong solution of carbolic acid, in the sinus.

In acute alveolar abscess where there is much swelling of the face, it is often well to endeavor to cause the abscess to point on the buccal surface of the gum over the root of the abscessed tooth. This can often be accomplished by the application of a counter-irritant, such as capsicum or cantharidine, to the gum overlying the root of the affected tooth. A roasted fig or raisin is said also to accomplish the same result.

All applications of hot fomentations, or poultices, or counter-irritants to the external surface of the face should be religiously avoided, and if the abscess seems to have a tendency to point externally a free incision for the pus should be made in the mouth, and the counter-irritants or other medicaments applied in the mouth. This will prevent many an opening on the face, and its consequent scar.

Constitutional treatment should not be neglected where indicated. A saline cathartic will often assist in hastening the removal of an acute abscess.

The author concludes his paper with the warning not to yield to the temptation to open the abscess on the face, when it points there, on account of the resulting scar and disfigurement.

Prophylaxis is of importance in the prevention of alveolar abscesses, but this belongs largely to the domain of the dentist. It

should, however, be the duty of every physician, whenever he finds decayed or offensive teeth present in any patient, to impress on them the importance of visiting their dentist and having their teeth attended to.

Dr. Samuel Theobald contributes a paper on

#### Radical Cure of Stricture of the Nasal Duct.

Advocating the passage of the larger sizes of probes on account of the danger of producing a false passage by means of the smaller ones.

His method of operating is first to anesthetize with cocaine and then pass a small probe, No. 2 usually, through the puncta, and canaliculus to look for, and finding it, to overcome any stricture at the juncture of the canal and sac. This facilitates the entrance of the probe-pointed canaliculus knife into the sac. Having slit up the canal he then passes a No. 5 or No 6 probe, or a smaller one if he fails with these. He anoints the probes with vaseline containing 10 per cent. of cocaine. Having surely entered the sac, we need not hesitate to use force in passing the stricture. He has never seen any serious consequences. Rarely he has had while using the small probes an ecchymosis of the lid, and once or twice slight inflammatory reaction. He does not think it advisable to probe daily unless compelled to do so for want of time. It may excite too much inflammation. Every other day is his custom. He increases by one number each time, skipping a number if very freely passed, or dropping back one if too tight. In two-thirds of all cases, including children, he has used a No. 16. Having reached the largest he intends to use, he then increases the intervals. The only objection he knows to the treatment is that the duct may remain too pervious and air pass freely when the nose is blown; but such inconvenience is, he thinks, very small.

In addition to probing, he prescribes collylie to be used three times a day; the most useful being a solution of bichloride of mercury 1-12000. Next to this, he prefers a solution of alum 10 grains to the ounce. He does not attack a fistula or carious bone, believing that they soon will take care of themselves if the passage is open. Patients may be taught to probe themselves with the larger probes. Strictureotomy has never appealed to him as rational treatment, nor has he ever had reason to destroy the lachrymal sac.

Under "Clinical Notes," Dr. J. N. E. Brown reports a case of

#### Compound Comminuted Fracture in the neighborhood of the Knee Joint: Recovery with Flavous Joint.

The treatment adopted was as follows:

The wound (from which there was considerable venous oozing) was flushed out with hot water, and subsequently with 1-4000 bichloride of mercury; three large drainage tubes were inserted, and a few points of silk suture introduced. An antiseptic dressing, consisting of moist bichloride gauze with absorbent cotton was applied. An interrupted long splint, extending from the axilla to the foot, was applied, with extension.

The patient recovered with an amount of shortening less than one inch: flexion and extension are restricted, the maximum amount of movement being through an angle of about ten degrees; when extended as far as possible, the limb is not quite straight, but is nearly so; an extensive cicatrix marks the site of the original wound.

Dr. William Oldright reports "A Case of Pneumo-hæmatothorax" which followed an injury. Patient recovered.

Dr. William Crawford reports a "Case of Placenta Previa with tendency to Post-partum Hemorrhage.

#### THE PACIFIC MEDICAL JOURNAL

for May contains a paper by Dr. John W. Robertson on

#### The Keeley Cure of Alcoholism.

The author reiterates the statement, now so frequently made as to become "a back number," that the basis of the treatment is strychnia. In his investigations of the subject, he arrives at precisely the same conclusions as Dr. Chauncy F. Chapman, whose article on "The Bichloride of Gold Treatment of Dipsomania" first appeared in the *Chicago Medical Recorder* and was reviewed at length in THE MEDICAL AND SURGICAL REPORTER for March 25, 1893.

The strychnine is the remedial basis of the injection and its virtues were fully recognized long before Keeley robbed it of its ancient name and honorable connections and rechristened it under the bastardized title of "Bichloride of Gold." One-fortieth of a grain of this drug is injected four times daily. In addition there is given for internal administration a mixture the basis of which is the well-known red extract of cinchona, which was long ago vaunted as a cure for alcoholism. The author advocates the use of strychnia not only in the lighter forms of alcohol poisoning but also for controlling delirium, stating that it is superior to morphin or chloral. In concluding his article he speaks as follows:

"My experience with the treatment of alcoholism and my acquaintance with alcoholics have been large, caused by my temporary connection with the Home of Inebriates. I am free to confess that I succeeded but indifferently well in the treatment of this disease, though I used the drugs I have so highly commended. Even when treating the same patient that was afterward benefited by a gold cure course, there was an element lacking which they supplied, viz, mystery as to the drug used and a positive assurance that they were receiving specific treatment. Another reason was that patients were unwilling to spend a month in getting well, and I could not give them the desired change of air and surroundings. The first reason for my lack of success no honest man can overcome, the second could be easily obviated, but without faith it is but a temporary expedient."

"If time should prove that the Keeley system does possess some eminent merits do

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## Periscope.

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not confound them with inhibitory influences. At last we are beginning to recognize the value of suggestion, hypnotic we call it, and it is this feature of the cure which may have a restraining influence on certain of the "graduates." Take away the mystery, and expose the bichloride treatment to the search light of truth, and then the value of the cure has departed and in its place stands a temporary aid and first guide in the art of curing drunkenness. With such a title no institution can flourish, for the drunkard knows his weakness, and, unaided, would never attempt to take the first steps necessary to his restoration. In conclusion I repeat that Keeley has no specific, no secret further than the secret of humbug, and if he made known his "cure" it would fall to pieces as do bones long entombed when exposed to air."

"I will match Keeley's secret as regards remedial value and scientific acumen with one I recently found in the 1601 edition of Philemon Holland's translation of Pliny: 'For to avoid drunkennesse take the lungs of

an hog, be it bore or sow, it matters not, in like manner of a kid, and rost it; whosoever eateth thereof fasting shall not be drunk that day how liberally soever he take his drinke.'

The remaining articles in this issue are The Presidential Address delivered before the Medical Society of the State of California, by Dr. W. E. Taylor; and the Report of the Committee on Obstetrics and Puerperal Diseases to the same body by Dr. Charlotte B. Brown. Antiseptics is insisted upon. The use of ergot, the report states, is more and more condemned by late writers. Hemorrhage from atony can generally be overcome by hot flushings of the vagina, or even the uterus, using a return catheter, much more promptly than ergot can act. But if this fail, the introduction of a piece of iodoform gauze acts at once and with no danger. Placenta previa having been diagnosticated, temporizing is out of place—labor should be induced at once. For the prevention of ophthalmia in the new born, the use of a boracic acid douche is advocated.

## PERISCOPE.

## MEDICINE.

## Infantile Paralysis.

At first, according to Dr. J. Simon, external methods are used, slight revulsion over the spinal cord about the origin of the roots of the nerves, with dry cups or application of croton oil mixed with some menstruum; or mustard leaves rather than the cautery points and the other more painful methods of vesication. Next give stimulating baths (in bed), using vapors, etc. Thirdly, sedation of the nervous system by chloral, aconite, or conium. In the second week combine electricity with tonics as follows: Galvanization by weak, continuous currents, (two to four milliamperes). Apply the positive pole by slipping it on the shoulder, and put the negative pole in a basin of water slightly salted, into which the hand is put, use this for eight to ten minutes, and notice that the positive pole does not blister the shoulder. If it gets too red reduce the strength of the battery. Later, use the faradic current as a change, but with weaker current. Slight massage and friction may be made also. Give the following:

R	Tinct. Nux Vomica.....	15 grains.
	Tinct. Colombo .....	1½ drachms.
	Tinct. Cascarellie.....	1½ drachms.

In eight or ten days commence an arsenical treatment by a half to one milligramme of sodii arsenicas.

During convalescence use sulphur baths or salt-water baths, or sea baths, for three minutes at a time only.—*Arch. of Ped.*

## SURGERY.

## Intravesical Injections of an Ethereal Solution of Iodoform in oil.

In the treatment of either acute or chronic cystitis, the above method has been employed by Dr. Okev Blom, Finland, with excellent results (*Ann. d. Mal. d'Org. Genito. Urin.*)

He advocates the use of a solution consisting of one gramme of iodoform dissolved in seven grammes of sulphuric ether, to which seven grammes of olive oil are added. The oil is added to modify the irritation produced by ether on the vesical mucous membrane. This is injected into the bladder and allowed to remain as long as possible. The frequency with which the injections are given, depends on the nature of the case.

In some patients they should be given daily; and others every other day; and others only require to have the injections made once in several days.

The most marked improvement was shown in acute cases of gonorrhoeal origin.

It is not claimed that this is a universal remedy for cystitis, but in about eleven cases out of twelve its action is most efficient.

During the treatment the patient should abstain from alcoholics and live as much as possible upon a milk diet.

## Syphilis and Wounds.

In syphilitic subjects, wounds, as Dr. G. Frank Lydston has shown, take on decidedly abnormal action. In the treatment of these cases Dr. A. C. Bernays of St. Louis has found calcium iodio and bromide (elix. iodo-brom. calciumdemp.) of great value.

## GYNECOLOGY.

## Laceration of the Cervix.

Dr. Fraisse (*Nouvelles Atch. de Obstet. et de Gyn.*) holds that every delivery at term in a primapara is accompanied by a laceration of the cervix. When it is of the first degree it undergoes immediate repair, and is shown only by a transverse elongation of the os.

The first symptom of severe laceration is hemorrhage, appearing previous to expulsion of placenta and reappearing after the third day of labor is completed. The blood comes in jets, and is fluid and bright red. Dr. Fraisse formulates this statement: If the uterus is firmly contracted, and there are no external lesions, any abundant hemorrhage may be assumed to have its origin in a laceration of the cervix which extends beyond the insertion of the vagina." Such a wound greatly increases the dangers of local and general infection.

The treatment of the hemorrhage consists in pressing the cervix upward towards the symphysis by means of the left hand introduced into the posterior cul-de-sac, the right hand seizing the body of the uterus externally and maintaining it in a position of anteflexion for about ten minutes. One such maneuver is usually effective, but it may have to be repeated; should it fail, a continuous catgut suture may be at once applied.

## (338) Ichthyol in Gonorrhœa.

Jadasson (*Deutsch. Med. Woch.* 1892, Nos. 38, 39) speaks highly of ichthyol for gonorrhœa in women as well as in men. In thirty-seven cases occurring in females the results of treatment were excellent. Ichthyol can readily be applied to the cervix, and also, later on in these cases, to the endometrium with an ordinary Playfair's probe covered with wool; a 10 per cent. ointment is sufficient. The probe may also be used for the urethra; a weaker preparation—from 1 to under 10 per cent.—is needed. It may, however, be injected, and, in some cases, the urethra should be packed with gauze dipped in the ichthyol, and introduced through a urethral speculum.—*Brit. Med. Jour.*

## ARMY AND NAVY.

## U. S. ARMY FROM MAY 21., 1893, TO MAY 27., 1893.

Leave of absence for twenty-five days to take effect on or about June 5, 1893, is hereby granted Major D. G. Caldwell, Surgeon, U. S. Army.

The leave of absence on surgeon's certificate of disability, for treatment in the Army and Navy General Hospital, granted Capt. Freeman V. Walker, Assistant Surgeon is extended to June 30, 1893.

First Lieut. James Kennedy, Assistant Surgeon U. S. Army, (recently appointed), will proceed from Troy, Abbeville Co., S. C., and report in person to the commanding officer, Fort Riley, Kansas, at that post.

By direction of the President, Major John O. Skinner, will report in person to Col. Henry W. Closson, Fourth Artillery, president of the Army retiring board at Washington Barracks, D. C., when required by the board for examination by it.

First Lieut. Alexander N. Stark, Assistant Surgeon, will proceed from Norfolk, Va., and report to the Commanding Officer, Fort Monroe, Va., for duty at that post.

First Lieut. John S. Kulp, Assistant Surgeon, will proceed from Wilkesbarre, Pa., and report to the Commanding Officer, Columbus Barracks, O., for duty at that post.

First Lieut. James D. Glennan, Assistant Surgeon U. S. A., is relieved from further duty in the Department of Texas, and ordered to join his proper Station, Fort Sill, Okla. Ty.

First Lieut. Edward L. Munson, Assistant Surgeon, will proceed from New Haven, Conn., and report to the Commanding Officer, Jefferson Barracks, Mo., for duty at that post.

First Lieut. Charles E. B. Flagg, Assistant Surgeon, will proceed from Indianapolis, Ind., and report to the Commanding Officer, Presidio, of San Francisco, Cal., for duty at that post.

First Lieut. Charles Lynch, Assistant Surgeon, will proceed from Syracuse, N. Y., and report to the Commanding Officer, Fort Omaha, Neb., for duty at that post.

First Lieut. Guy C. M. Godfrey, Assistant Surgeon, U. S. Army, ordered to proceed to Fort D. A. Russell, Wy., and report in person to the Commanding Officer of that post for duty.

## The World's Fair.

## FINAL ARRANGEMENTS FOR THE SALE OF TICKETS VIA THE B. &amp; O. R. R.

For the benefit of those desiring to attend the World's Fair the Baltimore & Ohio Railroad will sell Excursion tickets to Chicago and return, at all stations on its line, at low rates. Tickets will be on sale until November 1st, and will be valid for return journey until November 15th, 1893. They provide for a reduction of 20 per cent. below regular rates. These ticket will be valid only for continuous journey. Tickets at higher rates will be sold that will permit holders to stop over at Baltimore, Washington, or any other point, going and returning.

Besides the opportunity of visiting Washington, a privilege afforded by no other route, tourists via the Baltimore & Ohio Railroad will traverse the historic Potomac Valley, the theatre of the war between the States. At Cumberland they will be offered a choice of routes, via Pittsburgh, or across the Allegheny mountains, 3,000 feet above the level of the sea and via Deer Park and Oakland, the famous summer resorts. The scenery along the Baltimore & Ohio route is the most picturesque in America. Pullman accommodations may be reserved in advance of journey. For rates and information apply to nearest B. & O. Ticket Agent, or Chas. O. Scull, General Passenger Agent, Baltimore, Md.